
# 2013 Medicare Fee Schedule for Speech-Language Pathologists

**American Speech-Language-Hearing Association**

4th Edition

January 17, 2013

## Summary of Revisions

### December 18, 2012 (2nd Edition)

- Pages 6-7: Claims-Based Data Collection Requirement for Therapy Services (Updated information regarding reporting)
- Pages 7-8: Physician Quality Reporting System (Added information on a new claims-based measure available to SLPs)
- Pages 15-16: Appendix 2 (Updated descriptions for G-codes)
- Pages: 17-19: Appendix 3 (Updated Case Scenarios)

### January 3, 2013 (3rd Edition)

- Page 4: Conversion Factor (Updated conversion factor information based on Congressional action)
- Page 5: Multiple Procedure Payment Reductions (Updated information based on Congressional action)
- Page 6: Therapy Cap and Alternatives (Updated information based on Congressional action)
- Pages 11-14: Table 2. Table 2. National Medicare Part B Rates for Speech-Language Pathology Services (Updated Medicare rates using final 2013 conversion factor)

### January 17, 2013 (4th Edition)

- Page 15: Appendix 2 (Corrected Motor Speech G-code for projected goal status)
- Pages 18-19: Appendix 3, Scenario 2 (Updated scenario based on new CMS guidance)

## General Information

This document was developed by the American Speech-Language-Hearing Association (ASHA) to provide an analysis of the 2013 Medicare Physician Fee Schedule, including comments on relevant policy changes, a list of CPT (Current Procedure Terminology © American Medical Association) codes used by speech-language pathologists with their national average payment amounts, and useful links to additional information.

Please check ASHA's Billing and Reimbursement website for the most up-to-date information (www.asha.org/practice/reimbursement/medicare/feeschedule/).

For additional information, please contact ASHA's Health Care Economics and Advocacy Team at reimbursement@asha.org.

# Table of Contents

# Overview

On November 1, 2012, the Centers for Medicare and Medicaid Services (CMS) released the final rule for the 2013 Medicare Physician Fee Schedule (MPFS). The 1,362-page document includes regulations and rates for implementation on January 1, 2013, for speech-language pathologists providing services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include the process for reporting therapy outcomes on the claim form, the Physician Quality Reporting System (PQRS), and new requirements for speech generating devices (SGDs). 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 Billing and Reimbursement website at www.asha.org/practice/reimbursement/medicare/feeschedule/. For questions, please contact reimbursement@asha.org.

# Analysis of the 2013 Medicare Physician Fee Schedule (MPFS)

ASHA's Health Care Economics and Advocacy Team reviewed relevant sections of the 2013 MPFS and developed the narrative below, an analysis of the key issues for speech-language pathologists (SLPs).

## Reimbursement Rates

SLPs will see changes in 2013 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 **Appendix 1** (pp. 10-14) for a listing of speech-language pathology procedures and corresponding national payment rates. For fees based on locality, visit ASHA's website at www.asha.org/practice/reimbursement/medicare/calculating-medicare-fee-schedule-rates/#Geographic.

### *Conversion Factor (CF)*

The CF is used to calculate MPFS reimbursement rates. CMS established a calendar year 2013 CF of $25.0008, which is 26.5% less than the 2012 CF of $34.0376. Although this reduction is mandatory because of a statutory formula known as the *sustainable growth rate* (SGR) it was averted by Congress through the *American Taxpayer Relief Act of 2012*, which President Obama signed into law on January 3, 2013. This eliminates the 26.5% reduction with a final 2013 CF of **$34.0376** and extends the therapy exceptions and manual medical review processes through December 31, 2013. For more information, see the Therapy Cap and Alternatives section on **page 6**.

### *Practice Expense*

The value of each Current Procedural Terminology (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 insurance (malpractice). 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 will experience 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 those 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 Health Care Professionals Advisory Committee (RUC 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 change over time while practice expense values fluctuate according to CMS payment formula policies.

For a detailed chart of final 2013 RVUs, contact reimbursement@asha.org.

***Multiple Procedure Payment Reductions (MPPR)***

The eight speech-language pathology procedures included in the 2012 MPPR policy will continue in 2013. 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 **April 1, 2013**. This per-day policy applies across disciplines and across settings, and is designed to save an estimated $1.8 billion in Medicare expenditures in 2013. Visit ASHA's website for more information on MPPR, including billing scenarios and a list of the eight codes subject to MPPR (www.asha.org/practice/reimbursement/medicare/calculating-medicare-fee-schedule-rates/#MPPR).

## Revised CPT Codes for Interpretation and Report of Endoscopic Evaluations

Effective January 1, 2013, three CPT codes for interpretation and report of certain endoscopic procedures will no longer contain the term *physician*. With this change, SLPs who have not passed the endoscope, but have been asked to interpret the images, may be able to bill for their time using the following revised codes:

- CPT 92613, Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; interpretation and report only
- CPT 92615, Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; interpretation and report only
- CPT 92617, Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording (FEESST); interpretation and report only

SLPs should check with their local Medicare contractor to make sure they may use these codes. An SLP who has performed the evaluation should use only the code for the endoscopic evaluation (CPT 92612, 92614, or 92616) and may not also bill the interpretation and report code. See **Table 2** (p. 11) for a listing of the revised codes and their corresponding payment rates. Information on the revised codes is also available on ASHA's website at http://www.asha.org/practice/reimbursement/coding/new_codes_slp.htm.

## Speech Generating Devices (SGD)

CMS will require a physician to have a face-to-face visit with a patient who needs one of four identified SGDs. Under current regulations, a physician ordering an SGD needs only a written evaluation of the patient signed by a certified SLP. Beginning **July 1, 2013**, a physician must document that a physician (or physician assistant, nurse practitioner, or clinical nurse specialist) has met with the patient within 6 months before the written order for the SGD. If the patient's physician does not see the patient, the physician must receive a note from another practitioner, as listed above, documenting the encounter.

The face-to-face requirement, which applies to about 150 codes in the Health Care Common Procedure Coding System (www.asha.org/practice/reimbursement/coding/hcpcs_slp.htm), is designed to reduce fraud, waste, and abuse. The four SGD codes subject to the new physician visit requirement are:

- E2502: Speech-generating device, digitized speech, using pre-recorded messages, 8–20 minutes

- E2506: Speech-generating device, digitized speech, using pre-recorded messages, greater than 40 minutes
- E2508: Speech-generating device, synthesized speech, required message formulation by speech and access by physical contact with the device
- E2510: Speech-generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access

## Therapy Cap and Alternatives

For 2013, CMS has calculated that the therapy cap will increase from $1,880 to **$1,900** for physical therapy and speech-language pathology services combined.

On January 3, 2013, the president signed into law the *American Taxpayer Relief Act of 2012,* which extends the therapy cap exceptions and manual medical review processes through December 31, 2013. The exceptions process allows providers to indicate that services beyond the cap ($1,900 for combined speech-language treatment and physical therapy) are medically necessary for the beneficiary. Providers use a –KX modifier on the claim to attest to medical necessity and the availability of documentation. Under the manual medical review process, providers must obtain pre-approval for speech-language and physical therapy services that exceed $3,700 in order to receive payment. Any services not submitted for pre-approval will be denied; the denial can be appealed with a medical review.

To protect beneficiaries, the law also requires providers to tell Medicare beneficiaries if services exceed the threshold by giving the patient an Advanced Beneficiary Notice prior to delivering services. If the provider fails to give the patient the form, the beneficiary is not responsible for the cost of the services deemed not medically necessary in the review process

Although in previous years the therapy cap applied only to therapy services provided by private practitioners and outpatient rehabilitation facilities, the *Tax Relief Act* extends the therapy cap to services in hospital outpatient departments that were included October, 2012, and adds outpatient therapy services provided in critical access hospitals effective. This provision took effect Jan. 1.

ASHA will continue to work with CMS to develop alternatives to the therapy caps. For more information on the therapy cap exceptions process and the manual medical review go to ASHA's website at www.asha.org/practice/reimbursement/ExceptionProcess/.

## Claims-Based Data Collection Requirement for Therapy Services

The final rule responds to mandates from the Middle Class Tax Relief and Job Creation Act (MCTRJCA) of 2012 (Pub. L. 112-96) regarding the implementation of a claims-based data collection strategy for reporting patient condition and outcomes, "designed to assist in reforming the Medicare payment system for outpatient therapy services." Congress and CMS have been exploring alternatives to therapy payment since the introduction of the therapy caps in 1997.

CMS is proposing that the claims-based data collection strategy they have designed will collect information on beneficiary function and condition, therapy services furnished, and outcomes achieved. The implementation date is **January 1, 2013**, with a 6-month testing period. Claims that do not comply with the data reporting requirements will be returned unpaid beginning **July 1, 2013**.

### *Reporting on the Claim Form*

The final rule established non-payable G-codes for reporting on claims by adopting seven of the Functional Communication Measures (FCMs) used by ASHA's National Outcomes Measurement System (NOMS) and one miscellaneous measure to be used for patients that are not represented in one of the seven measures. Each non-payable G-code listed on the claim form must be accompanied with a severity/complexity modifier. The modifier represents the functional impairment on a 7-point severity/complexity scale.

To assist with the Medicare documentation requirements, ASHA is reconfiguring NOMS to automatically generate the appropriate G-code and modifier when NOMS participants enter their FCM data. Visit ASHA's website for more information on NOMS (http://www.asha.org/Members/research/NOMS/).

The G-codes and modifiers are listed in **Appendix 2** (p. 15). ASHA has also developed two scenarios (**Appendix 3**, pp. 17-19) to help SLPs understand the claim process.

Implementation of the non-payable G-codes with the severity modifier includes the following standards:

*Reporting*

- Reporting is required for all therapy services, not just services above the therapy cap.
- If a patient is seen by more than one discipline, each discipline should report the status and severity for their plan of care.
- Reporting (but not treatment) is limited to one functional limitation at a time throughout the episode of care, even for those patients who qualify and will be treated for multiple categories. The primary functional limitation should be chosen, and, after the treatment goal is achieved for the primary, a subsequent functional limitation should be reported in the same manner as the primary code was reported.
- The primary long-term treatment goals should be reported with every reported patient status, including each time an evaluation code is billed, using the appropriate G-code and severity modifier.
- Reporting should occur at admission, discharge, each time an evaluation code is billed, and every 10th treatment day, consistent with the timing requirements for progress reports.
- Discharge reporting is required, except for those cases where therapy services are discontinued by the beneficiary prior to the planned discharge visit and the claim was submitted prior to that knowledge.

*Documentation*

- Documentation requirements begin January 1, 2013.
- The Medicare policy manuals will be modified to delete the 30 calendar day language and only include 10 treatment days. 10 treatment days is the minimum, and documentation can occur more often. Additional reporting, however, is not necessary.
- The alpha-numeric G-codes and the related modifiers must be documented in the beneficiary's medical record, also with the tool and/or justification of how the severity modifier was determined with every progress note.
- It is acceptable to document and report the save severity modifier for the current status and goal when the improvement is expected to be limited, or for those individuals receiving maintenance therapy.

*Claim Form*

- Prior to July 1, 2013, all current therapy patients should have started the reporting cycle with the G-codes added to the claim for therapy services.
- The therapy modifier –GN is still required on the claim form to indicate the therapy service is furnished under the SLP plan of care. The –GN modifier is also required for all of the G-codes reported on the claim.
- For each line of the institutional claim, a charge of $0.01 should be added for the non-payable G-code. For each line of the professional claim submitted by private practice providers, a charge of $0.00 or $0.01 should be added, depending on the requirements of your billing system.
- Claims must have a payable code for processing, so reporting must be accompanied by a furnished service. Do not submit a claim with only the non-payable G-codes.

- Should Congress extend the therapy cap exceptions process, services over the therapy cap will require the –KX modifier. However, the –KX modifier should not accompany the non-payable G-code, only the billable service.

## Physician Quality Reporting System (PQRS)

The PQRS, designed to support improvements in quality of care for Medicare Part B patients by tracking practice patterns, began as a voluntary incentive payment program. Eligible providers earn an incentive payment for reporting their patient data. As the program has continued, however, the incentive payment has decreased incrementally to the current 0.5% incentive payment based on total claims. PQRS will remain an incentive program through 2014, but will change to a deduction program beginning in 2015 based on 2013 participation.

The final rule includes different benchmark requirements based on qualification for receiving the 0.5% incentive payment or avoiding the deductions later. A deduction of 1.5% from all 2015 Part B payments to health care providers who did not report on at least one measure in 2013 will be applied to all claims. However, the benchmark for qualifying for incentive payments in 2013 and 2014 includes reporting on at least three measures or the number of available measures to report, if fewer than three are available. The table below delineates the differences for SLPs:

**Reporting Requirements**

| **2013-2014 Participation Requirements** ***To Receive Incentive Payment*** | **2013Participation Requirements** ***To Avoid 2015 Deductions*** |
|---|---|
| • 80% of eligible cases<br>• Minimum of three measures<br>• Reported through NOMS or other registry | • Minimum of one measure<br>• Reported through NOMS or other registry |

SLPs can report measures for adult patients with a diagnosis related to stroke through ASHA's NOMS, an official PQRS registry. ASHA submits NOMS data on behalf of PQRS-registered participants. SLPs can report on functional communication measures, including spoken language comprehension, spoken language expression, motor speech, writing, reading, attention, memory, and swallowing.

Claims-based reporting is available for SLPs who want to ensure compliance with the PQRS program but do not participate in NOMS. SLPs can report *Measure #130: Documentation of Current Medications in the Medical Record*, each time they see a Medicare Part B patient receiving speech therapy, swallowing therapy, or cognitive therapy services by indicating that each visit includes documentation of current medications in the medical record, including prescription, over-the-counter, herblas, nutritional supplements, drug name, dosage, frequency and route (e.g., oral, injection).

Eligible providers are those private practice or group practices submitting claims with individual National Provider Identification (NPI) numbers, providing services to Part B Medicare beneficiaries for certain conditions and billing for services under the MPFS, are subject to this adjustment. Please visit ASHA's PQRS web page at www.asha.org/Members/research/NOMS/PQRI/ for more information on the measures to report and how to register for PORS reporting through the NOMS registry.

# Appendices

## Appendix 1: 2013 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 |
|---|---|---|---|---|
| 92506 | 92618 | 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 | |
| 92609 | | | | |

The following table contains full descriptors and national payment rates for speech-language pathology related services. Calculations were made using the final 2013 conversion factor ($34.0376).

Please see www.asha.org/practice/reimbursement/medicare/feeschedule/ for important information on Medicare CPT coding rules and calculating Medicare fees, 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 Final 2013 Rates | Notes |
|---|---|---|---|
| **31579** | Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy | **$217.84** | This procedure may require physician supervision based on MACs' (Medicare Administrative Contractors) local coverage policies or state practice acts. |
| **92506** | Evaluation of speech, language, voice, communication, and/or auditory processing | **$217.16** | |
| **92507** | Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual | **$71.14** | |
| **92508** | group, 2 or more individuals | **$20.76** | |
| **92511** | Nasopharyngoscopy with endoscope (separate procedure) | **$143.64** | This procedure may require physician supervision based on MACs' local coverage policies or state practice acts. |
| **92512** | Nasal function studies (eg, rhinomanometry) | **$62.97** | |
| **92520** | Laryngeal function studies (ie, aerodynamic testing and acoustic testing) | **$74.88** | |
| **92526** | Treatment of swallowing dysfunction and/or oral function for feeding | **$77.27** | |
| **92597** | Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech | **$69.10** | |
| **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 and instructs SLPs to use 92506 for non-SGD evaluation (*Federal Register*, December 31, 2002, p. 80010). |
| **92618** | each additional 30 minutes (List separately in addition to code for primary procedure) | **$0.00** | This is an add-on code for 92605. CMS will not pay for this code and instructs SLPs to use 92506 for a non-SGD evaluation. |

| CPT Code | Descriptor | National Fee Final 2013 Rates | Notes |
|---|---|---|---|
| **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 and instructs SLPs to use 92507 for non-SGD treatment. |
| **92607** | Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour | **$119.13** | |
| **92608** | each additional 30 minutes (List separately in addition to code for primary procedure) | **$47.65** | |
| **92609** | Therapeutic services for the use of speech-generating device, including programming and modification | **$98.37** | |
| **92610** | Evaluation of oral and pharyngeal swallowing function | **$77.95** | |
| **92611** | Motion fluoroscopic evaluation of swallowing function by cine or video recording | **$87.48** | |
| **92612** | Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording; | **$179.72** | This procedure may require physician supervision based on MACs' local coverage policies or state practice acts. |
| **92613** | interpretation and report only | **$38.12** | Revised for 2013 to remove the term *physician*. For details, see ***Revised CPT Codes*** (p. 5). |
| **92614** | Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording; | **$154.53** | This procedure may require physician supervision based on MACs' local coverage policies or state practice acts. |
| **92615** | interpretation and report only | **$33.02** | Revised for 2013 to remove the term *physician*. For details, see ***Revised CPT Codes*** (p. 5). |
| **92616** | Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; | **$212.05** | This procedure may require physician supervision based on MACs' local coverage policies or state practice acts. |
| **92617** | interpretation and report only | **$41.19** | Revised for 2013 to remove the term *physician*. For details, see ***Revised CPT Codes*** (p. 5). |
| **92626** | Evaluation of auditory rehabilitation status; first hour | **$89.52** | SLPs may report this evaluation code. |
| **92627** | each additional 15 minutes (List separately in addition to code for primary procedure) | **$21.44** | 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. |

| CPT Code | Descriptor | National Fee Final 2013 Rates | Notes |
|---|---|---|---|
| **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 | **$93.94** | |
| **96110** | Developmental screening, with interpretation and report, per standardized instrument form | **$0.00** | 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 | **$126.96** | |
| **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 | **$107.90** | |
| **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 | **$26.21** | |
| **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 | **$28.93** | |
| **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 | **$34.72** | Except for CPT 97532 and CPT 97533, 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 | **$9.19** | 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 | Notes |
|---|---|---|---|
| **31575** | Laryngoscopy, flexible fiberoptic; diagnostic | **$117.77** | This procedure is for medical diagnosis by a physician. |
| **70371** | Complex dynamic pharyngeal and speech evaluation by cine or video recording | **$93.60** | This is a radiology code. |
| **74230** | Swallowing function, with cineradiography/videoradiography | **$93.94** | This is a radiology code. |
| **76536** | Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation | **$125.60** | This is a radiology code. |

## Appendix 2: G-Codes & Modifiers for Outcome Reporting on the Claim Form

**Table 4. G-Codes**

| G-Codes | Functional Limitation & Status |
|---|---|
| **Swallowing** | |
| G8996 | Swallowing functional limitation, **current status** at time of initial therapy treatment/episode outset and reporting intervals |
| G8997 | Swallowing functional limitation, **projected goal status**, at therapy episode outset, at reporting intervals, and at discharge or to end reporting |
| G8998 | Swallowing functional limitation, **discharge status**, at discharge from therapy/end of reporting on limitation |
| **Motor Speech** | |
| G8999 | Motor speech functional limitation, **current status** at time of initial therapy treatment/episode outset and reporting intervals |
| G9186 | Motor speech functional limitation, **projected goal status**, at therapy episode outset, at reporting intervals, and at discharge or to end reporting |
| G9158 | Motor speech functional limitation, **discharge status** at discharge from therapy/end of reporting on limitation |
| **Spoken Language Comprehension** | |
| G9159 | Spoken language comprehension functional limitation, **current status** at time of initial therapy treatment/episode outset and reporting intervals |
| G9160 | Spoken language comprehension functional limitation, **projected goal status**, at therapy episode outset, at reporting intervals, and at discharge or to end reporting |
| G9161 | Spoken language comprehension functional limitation, **discharge status** at discharge from therapy/end of reporting on limitation |
| **Spoken Language Expression** | |
| G9162 | Spoken language expression functional limitation, **current status** at time of initial therapy treatment/episode outset and reporting intervals |
| G9163 | Spoken language expression functional limitation, **projected goal status**, at therapy episode outset, at reporting intervals, and at discharge or to end reporting |
| G9164 | Spoken language expression functional limitation, **discharge status** at discharge from therapy/end of reporting on limitation |
| **Attention** | |
| G9165 | Attention functional limitation, **current status** at time of initial therapy treatment/episode outset and reporting intervals |
| G9166 | Attention functional limitation, **projected goal status**, at therapy episode outset, at reporting intervals, and at discharge or to end reporting |
| G9167 | Attention functional limitation, **discharge status** at discharge from therapy/end of reporting on limitation |

| G-Codes | Functional Limitation & Status |
|---|---|
| **Memory** | |
| G9168 | Memory functional limitation, **current status** at time of initial therapy treatment/episode outset and reporting intervals |
| G9169 | Memory functional limitation, **projected goal status**, at therapy episode outset, at reporting intervals, and at discharge or to end reporting |
| G9170 | Memory functional limitation, **discharge status** at discharge from therapy/end of reporting on limitation |
| **Voice** | |
| G9171 | Voice functional limitation, **current status** at time of initial therapy treatment/episode outset and reporting intervals |
| G9172 | Voice functional limitation, **projected goal status**, at therapy episode outset, at reporting intervals, and at discharge or to end reporting |
| G9173 | Voice functional limitation, **discharge status** at discharge from therapy/end of reporting on limitation |
| **Other Speech-Language Pathology Functional Limitation** | |
| G9174 | Other speech language pathology functional limitation, **current status** at time of initial therapy treatment/episode outset and reporting intervals |
| G9175 | Other speech language pathology functional limitation**, projected goal status**, at therapy episode outset, at reporting intervals, and at discharge or to end reporting |
| G9176 | Other speech language pathology functional limitation, **discharge status** at discharge from therapy/end of reporting on limitation |

**Table 3: G-Code Modifiers**

| Modifier | Impairment Limitation Restriction | NOMS Level |
|---|---|---|
| CH | 0% impaired, limited or restricted | 7 |
| CI | At least 1% but less than 20% impaired, limited or restricted | 6 |
| CJ | At least 20% but less than 40% impaired, limited or restricted | 5 |
| CK | At least 40% but less than 60% impaired, limited or restricted | 4 |
| CL | At least 60% but less than 80% impaired, limited or restricted | 3 |
| CM | At least 80% but less than 100% impaired, limited or restricted | 2 |
| CN | 100% impaired, limited or restricted | 1 |

## Appendix 3: Case Scenarios for Outcome Reporting on the Claim Form

Please refer to the sample CMS 1500 claim form (www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS1500805.pdf [PDF]) and Appendix 2 for G-Code (p. 15) and Modifier (p. 16) descriptions.

### *Scenario 1: Patient Seen for One Functional Limitation*

Patient presents with a history of CVA and was referred because of severely reduced speech intelligibility. Language and cognitive function are normal. The patient can produce short consonant-vowel combinations, but is rarely intelligible in context. Plan of care is for 12 visits, with goal for intelligibility in routine activities with familiar and unfamiliar partners.

- **Functional limitation:** Motor Speech (G-code: G8999), NOMS Level 2 (Modifier: CM)
- **Projected goal:** Motor Speech (G-code : G9186), NOMS Level 5 (Modifier: CJ)

**Reporting on the Initial Claim**

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92506**, Modifier: **GN**
  - **Line 2:** CPT/HCPCS: **G8999**, Modifier: **GN, CM** (Current status of motor speech limitation)
  - **Line 3:** CPT/HCPCS: **G9186**, Modifier: **GN, CJ** (Projected goal for motor speech limitation)

**Reporting on the Claim for Visits #2-#9**

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92507**, Modifier: **GN**
  - No additional outcome/goal reporting

**Reporting on the Claim for Visit #10** (Reporting must occur at least once every 10 treatment days)

**Status:** Patient has progressed to being able to produce short phrases intelligibly with moderate cuing (NOMS Level 4).

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92507**, Modifier: **GN**
  - **Line 2:** CPT/HCPCX: **G8999**, Modifier **GN, CK** (Current status of motor speech limitation)
  - **Line 3:** CPT/HCPCS: **G9186**, Modifier: **GN, CJ** (Projected goal for motor speech limitation)

**Reporting on the Claim for Final Visit** (Patient discharged from plan of care)

**Status:** Patient intelligible in routine activities (NOMS Level 5).

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Lines 1–2:** CPT/HCPCS: **92507** and/or **92506** (see note below)
  - **Line 3:** CPT/HCPCS: **G9158**, Modifier: **GN, CJ** (Status of motor speech limitation at discharge)
  - **Line 4:** CPT/HCPCS: **G9186**, Modifier: **GN, CJ** (Status of projected motor speech goal at discharge=goal met)

**ASHA Note:** Final visit may include treatment (92507) and/or re-evaluation (92506). The *Medicare Benefit Policy Manual* states that "a re-evaluation may be appropriate prior to planned discharge for the purpose of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued."

Please refer to the sample CMS 1500 claim form (www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS1500805.pdf [PDF]) and Appendix 2 for G-Code (p. 15) and Modifier (p. 16) descriptions.

***Scenario 2: Patient Seen for Multiple Functional Limitations***

Patient presents post CVA with expressive and receptive aphasia. The patient is able to follow simple directions with maximal cues, verbal attempts to speak are not meaningful or accurate, and consistent moderate cues are necessary for safe swallowing. The speech language evaluation reveals severe expressive and receptive language scores, and the swallowing evaluation indicates a moderate-severe swallowing deficiency.

- **Functional Limitations:**
  - Swallowing (G-code: G8996), NOMS Level 2 (Modifier: CM)
  - Spoken Language Comprehension (G-code: G9159), NOMS Level 2 (Modifier: CM)
  - Spoken Language Expression (G-code: G9162), NOMS Level 1 (Modifier: CN)

CMS allows the reporting of **one** functional limitation at a time. For this case, it was determined that **Swallowing** would be reported initially.

- **Projected goal:** Swallowing (G-code G8997), NOMS Level 6 (Modifier: CI)

**Reporting on the Initial Claim**

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92610**, Modifier: **GN**
  - **Line 2:** CPT/HCPCS: **92506**, Modifier: **GN**
  - **Line 3:** CPT/HCPCS: **G8996**, Modifier: **GN, CM** (Current status of swallowing limitation)
  - **Line 4:** CPT/HCPCS: **G8997**, Modifier: **GN, CI** (Projected goal for swallowing)

**Reporting on the Claim for Visits #2–#9**

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92507**, Modifier: **GN**
  - **Line 2:** CPT/HCPCS: **92526**, Modifier: **GN**
  - No additional outcome/goal reporting

**Reporting on the Claim for Visit #10** (Reporting must occur at least once every 10 treatment days)

**Status:** Patient has progressed, swallowing is safe, but usually requires moderate cues to use compensatory strategies (NOMS Level 4).

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92507**, Modifier: **GN**
  - **Line 2:** CPT/HCPCS: **92526**, Modifier: **GN**
  - **Line 3:** CPT/HCPCX: **G8996**, Modifier **GN, CK** (Current status of swallowing limitation)
  - **Line 4:** CPT/HCPCS: **G8997**, Modifier: **GN, CI** (Projected goal for swallowing)

*Scenario continued on next page*

**Reporting on the Claim for Visit #18** (Patient was discharged from swallowing therapy)

**Status:** The SLP determines reassessment is necessary. Goals were met for swallowing, but spoken language comprehension and expression have not met therapy goals. The claim will indicate a discharge from the plan of care for swallowing, and the following claim will report the secondary condition of spoken language comprehension.

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92506**, Modifier: **GN**
  - **Line 2:** CPT/HCPCS: **92610**, Modifier: **GN**
  - **Line 3:** CPT/HCPCS: **G8998**, Modifier: **GN, CI** (Status of swallowing limitation at discharge)
  - **Line 4:** CPT/HCPCS: **G8997**, Modifier: **GN, CI** (Status of swallowing projected goal at discharge= goal met)

**Reporting on the Claim for Visits #19** (Patient continues therapy for spoken language comprehension)

**Status:** Therapy is still necessary for spoken language comprehension, as moderate contextual support and cueing are necessary (NOMS Level 4). The claim will indicate the continued care, and **spoken language comprehension** will be reported on the claim with the goal of **NOMS Level 6**.

- **Box 24.D. (Procedure, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92507**, Modifier: **GN**
  - **Line 2:** CPT/HCPCS: **G9159**, Modifier: **GN, CK** (Current status of spoken language comprehension)
  - **Line 6**: CPT/HCPCS: **G9160,** Modifier: **GN, CI** (Projected goal for spoken language comprehension)

**Reporting on the Claim for Visits #20–#27**

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92507**, Modifier: **GN**
  - No additional outcome/goal reporting

**Reporting on the Claim for Final Visit** (Patient discharged from plan of care)

**Status:** Patient has plateaued in therapy progression at **NOMS Level 5**. The patient is discharged from the plan of care.

- **Box 24.D. (Procedures, Services, or Supplies)**
  - **Line 1:** CPT/HCPCS: **92507**, Modifier: **GN**
  - **Line 2:** CPT/HCPCS: **G9161**, Modifier: **GN, CJ** (Status of spoken language comprehension at discharge)
  - **Line 3:** CPT/HCPCS: **G9160**, Modifier: **GN, CI** (Status of spoken language comprehension projected goal at discharge=goal not met)

For additional scenarios, go to www.asha.org/practice/reimbursement/medicare/Claims-Based-Outcomes-Reporting-for-Medicare-Part-B/.