http://www.asha.org/members/issues/reimbursement/coding/TimedCodesFAQs.htm

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See also: Is There a 15-Minute Billing Code in Our Future?

Questions:

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Can procedure codes be billed by units of time?

Most speech-language pathology codes do not have time units assigned to them, specifically 92506 (speech-language evaluation) and 92507 (speech-language treatment). If no time is noted in the descriptor, each code counts as one session. These codes are listed in ASHA's "Health Plan Coding and Claims Guide" (available through the ASHA Online Store; Item #0112486). A complete list of the CPT codes for speech-language pathology and audiology services can also be found in the ASHA Medicare Fee Schedule or the ASHA Model Superbill for Speech-Language Pathology Practice [PDF].

Are there any speech-language pathology timed codes?

Yes. CPT codes related to evaluation for a speech-generating augmentative/alternative device (92606) can be billed in a one hour unit for the first hour with an add-on code (and 92607) for each additional 30 minutes. Aural rehabilitation assessment (92626) is billed in a one hour unit and 92627 is for each additional 15 minutes. Assessment of aphasia (96105) is billed per hour.

Why isn't ASHA moving toward adding time units?

Please be aware that ASHA representatives requested time units be added to the speech-language treatment procedure descriptor in 1994 but the request was not accepted by the American Medical Association's (AMA) CPT Editorial Panel. The Panel noted that "time" was already factored into the formula that values the procedure. At the present time, adding time units is a lengthy multi-step process and has the potential of yielding unfavorable results. For example, if time units were added to the descriptor, the procedure would be "re-valued" and, as such, an even lower reimbursement rate could be assigned. This possibility exists each time a procedure is redefined.

The Medicare formula for determining reimbursement for these codes is undergoing examination and deals with a concept called physician work. At the present time, the physician work component adds value to 92507. Any revision of the procedure descriptor alone would beg the question, "What does a physician do during these treatment procedures?" If the answer is "nothing" then it is very possible that the relative value for that part of the reimbursement formula would be changed to zero and, consequently, the rate would be reduced. ASHA is now in the process of negotiating with CMS and the AMA RUC so that the services of the speech-language pathologist as well as a physician can be reflected in the work component.

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Why can't "complexity" of care be accounted for in the codes?

If the treatment code (92507) is revised, the development of additional treatment codes that could address complexity of services would be

considered at that time. ASHA would have to present evidence that the services are different in terms of the time it takes to perform the service, the level of technical skill, the physical effort, the required mental effort and judgment, and the stress due to the potential risk to the patient.

Are there any guidelines or data available on what constitutes the typical time allowed for a speech-language pathology session?

ASHA conducted a survey and found that 45- 60 minutes was a typical session length, although more recent feedback from speech-language pathologists indicates that typical sessions are moving closer toward 30 minutes. This survey information is also used by the Centers for Medicare & Medicaid (CMS) and the AMA's relative value process.

Why don't SLPs have time units like the PT/OT codes?

Historically, the physical medicine and rehabilitation procedure codes were assigned time units of 15 minutes while the codes for speech-language pathology were not. Because of the way codes are developed and established, it is difficult to revise descriptors. There are two 15-minute treatment codes available to speech-language pathologists under Medicare – CPT *97532, Development of cognitive skills, each 15 minutes*; and *97533, Sensory integrative techniques, each 15 minutes*. Note that Medicare assigns 97532 a total value of 0.66 which converts to a national fee of $25.01. CPT 97533 has a total value of 0.70 and a national fee of $26.53. These are in contrast to 92507 which has a total value of 1.67 and a national fee of $63.29.

CPT	Short Descriptor	Physician Work RVUs	Practice Expense RVUs	Malpractice Expense RVUs	Total RVU	Fee
92507	Speech, language treatment	0.52	1.13	0.02	1.67	$63.29
97532	Cognitive skills development,	0.44	0.21	0.01	0.66	$25.01

	each 15 minutes					
97533	Sensory integration, each 15 minutes	0.44	0.25	0.01	0.70	$26.53

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Occasionally, I must spend an extremely long period of time rendering an evaluation or treatment session. Is there a way to be reimbursed an extra amount in recognition of the inordinate amount of time?

One of the CPT modifiers is –22, added at the end of the CPT code. This modifier denotes a session or procedure that is unusually long. Many payers will increase reimbursement by 25 to 50 percent when this modifier is included. Be warned that if you submit claims with the –22 modifier too often, the payer may conclude that the long sessions are not "unusual," and cease to honor the modifier.

If I spend 20 minutes treating a patient and bill the cognitive therapy CPT code 97532 (each 15 minutes), can I bill two units?

No. Medicare has established specific minimum and maximum times for 15-minute codes and most payers have adopted this policy. The minimum time for one 15-minute code is 8 minutes. Two units would be a minimum of 15 + 8 minutes = 23 minutes. This rule is extended to multiple units in the following CMS table:

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

Can I bill an untimed code more than once per day?

Medicare specifies that evaluation or assessment procedures may be billed only once per discipline, per date of service, per patient (CPT 92506, 92597, 92607, 92611, 92612, 92616). However, treatment codes can be billed for twice per day treatment if documentation shows the need for separate treatment sessions (e.g., patient fatigue). Many payers will adopt Medicare policy.

Reference: Medicare Claims Processing Manual, section 5/20.2.D [effective 1-2-07]

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