South Carolina Speech-Language Hearing Association

Frequently Asked Questions on CPT codes

Any information contained in this document should not be construed as legal advice and is not intended to be a substitute for legal counsel on any subject matter. All individuals who wish to verify legal requirements of license holders should consult the practice act and all relevant regulatory chapters for the practice of Speech-Language Pathology.

Terminology:
CPT = current procedural terminology (CPT© American Medical Association)
Timed codes: must spend at least 51% of the designated time face-to-face in evaluation or treatment.
Untimed codes: billed once per day regardless of the amount of face-to-face time

What is the SC Medicaid and Medicaid Managed Care Organizations (MCOs) perspective on the Speech-Language Pathology CPT codes?

The MCO's are contractually obligated to cover the minimum of what SC Medicaid covers: see the Private Rehabilitation and Therapy manual for standards on therapy services in the outpatient setting. The covered CPT codes are listed in the Private Rehabilitation and Therapy Manual, section 4 Procedure codes. They are also listed in the SCDHHS Provider Fee Schedules located on the SCDHHS website. There may be some CPT codes SLPs may bill for other carriers that are not covered under SC Medicaid when billed by an SLP. SCSHA continues to address the list of CPT codes and hopes for updates that expand the list in the next year.

The treatment code for speech/language therapy, CPT 92507, and the group speech/language therapy code, 92508, have been a point of contention for many years. During 2021-2023, SCSHA spent a great deal of advocacy time on CPT codes and has learned the following information about CPT codes 92507 and 92508:

1. Generally, 92507 and 92508 are untimed according to most commercial insurance carriers and Medicare.
2. For SC Medicaid, the speech therapy codes 92507 and 92508 are **15 minute**, unit-based codes. This means that in billing codes, the provider needs to be aware of the following limitations:
    a. Maximum of 4 units per date of service
    b. Must meet the 8-minute minimum rule for each unit (minimum of 8 minutes for 1 unit, 15+8 for 2 units, 30+8 for 3 units, 45+8 for 4 units).
    c. While this method of billing does not capture the complexity of 92507 or 92508 in terms of the bundled procedure code, and requires 53 or more minutes face-to-face time to bill for 4 units, it allows SC Medicaid to establish reimbursement rates that are not necessarily dependent on the *Medicare* rate, which would then tie the reimbursement to a percentage of that rate (currently 71%) according to the State Plan.

How do I know how much I can ethically bill?

1. What procedures were provided (including education)?
2. Is there a timed code involved?
3. Are there multiple codes involved?
4. What does the insurance/payer source allow?
5. Did I complete the full services of each bundled, untimed procedure code?

ASHA Resource on coding rules:
https://www.asha.org/practice/reimbursement/medicare/slp_coding_rules/

What if you're billing multiple different codes per day?
NCCI edits:
https://www.asha.org/practice/reimbursement/coding/national-correct-coding-initiative-for-audiology-and-speech-language-pathology-services/
Depending on the payer or carrier, some codes require the -59 modifier to be billed on the same day as another code while others do not. Some codes cannot be billed on the same day as another code (look for the "N" on the column of whether -59 can be used to bypass same day billing).

Common examples of same-day billing with multiple codes:
92610 + 92523 NO -59
92610 + 92526 NO -59
92507 + 92526 NO -59
92610 + 92611 or 92612. -59 is required
92507 + 92609 -59 is required
https://www.asha.org/practice/reimbursement/coding/cci-edit-tables-slp/

The -59 modifier indicates that services are *not typically provided on the same day,* but are appropriate under the circumstances. If your practice is billing services with -59 frequently, that could increase the likelihood of tags for payer source audits and could trigger denials. When providing services using the -59 modifier, make sure your documentation matches up.
My suggestion: add a separate heading under the "objective" portion of your note to delineate what data came from *each* procedure that was completed. I would advise you to do this whenever you are billing multiple codes per day, and not just in the circumstance of using the -59 modifier.

***There is currently no guidance from SC Medicaid on whether or not codes are required to be billed with the NCCI edits and -59 modifiers.** Some of the Medicaid Managed Care Organizations may enforce the NCCI edits since SC Medicaid does not list them in the fee schedule or in the Private Rehabilitation and Therapy manual.

Common restrictions with same day service provision and billing:
92507 cannot be paired with cognitive tx on the same day (97129, 97130) when the SLP provides both services
92507 CAN be paired with 92508 on the same day when provided by the SLP, but -59 is required
92523 cannot be paired with 92522 on the same day

When in doubt, check the NCCI edits table.
https://www.asha.org/practice/reimbursement/coding/cci-edit-tables-slp/

What about Medically Unlikely Edits (MUEs)?
ASHA information:
https://www.asha.org/practice/reimbursement/coding/medically-unlikely-edits-slp/

Essentially, MUE's show the **maximum number of units that can be billed for each code, per date of service**. This is where you can find the typical maximum units per day for timed codes (e.g. CPT code 96125 has MUE value of 2).

Untimed procedure codes have an **MUE of 1.**

The table from ASHA also includes MUEs on durable medical equipment, which are listed as HCPCS level 2 codes. If you don't commonly need DME in your practice, these codes will look unfamiliar to you. They cover things like laryngectomy and tracheostomy supplies, speech-generating devices, and rehabilitative respiratory equipment. DME suppliers should know the maximum number that can be billed but this is a way you can ensure denials don't occur due to conflicts from the prescription and MUEs.

If you are new to CPTs and want to review an introductory module all about CPTs from ASHA, you can view a module for free here:
https://www.asha.org/practice/reimbursement/module-one/
There are other reimbursement modules you can view for free:
https://www.asha.org/practice/reimbursement/modules/

ASHA Coding FAQs: https://www.asha.org/practice/reimbursement/coding/coding_faqs_slp/

Timed codes FAQs: https://www.asha.org/practice/reimbursement/coding/timedcodesfaqs/

"Does time factor into untimed codes?" – from an ASHA leader article by Neela Swanson:
https://leader.pubs.asha.org/doi/10.1044/leader.BML.23032018.30

"Although untimed codes do not include time units in their descriptors, underlying times associated with each CPT code have been used to determine the value of the evaluation or treatment. For example, CPT code 92507 has a total underlying time of 60 minutes, and CPT code 92557 has a total time of 28 minutes. These times are based on American Medical Association surveys of audiologists and speech-language pathologists that are conducted in conjunction with ASHA and other related specialty societies.

The time associated with each CPT code includes pre-service time (before you see the patient), intra-service time (one-to-one evaluation or treatment with the patient), and post-service time (after the evaluation or treatment service has been completed). Pre- and post-service times generally include time spent reviewing records, preparing for the session, discussion of results with the patient and family/caregivers, report writing, and communicating with other health care providers. Because these activities are included in the value of each code, they generally cannot be billed separately with additional codes.

Underlying times for all codes are available in the Physician Time File, updated annually on the Centers for Medicare and Medicaid Services website."

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F

For more resources on CMS and Medicare:

Here is an MLN matters newsletter that lists documentation requirements:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OutptRehabTherapy-Booklet-MLN905365.pdf

Chapter 15 from the Medicare manual:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Examples from the Physician Time File for commonly billed SLP codes

*Keep in mind that most of the SLP procedure codes are untimed. Providers are **not** required to complete the total time listed below in order to bill the codes.*

Code	Pre-service	Treatment	Post-service	Total
92507 (speech tx)	5 min	50 min	5 min	60 min
92508 (grp speech tx)	2 min	17 min	3 min	22 min
92521 (fluency eval)	5 min	90 min	15 min	110 min
92522 (SSD/motor speech eval)	5 min	60 min	20 min	85 min
92523 (speech & language eval)	7 min	120 min	30 min	157 min
92524 (voice/resonance eval)	5 min	60 min	10 min	75 min
92610 (swallow/oral fxn eval)	7 min	35 min	10 min	52 min
92526 (swallow/oral fxn tx)	5 min	45 min	5 min	55 min
92611 (modified barium swallow)	7 min	30 min	10 min	47 min
92612 (flexible endoscopic eval of swallow)	10 min	15 min	7 min	32 min
92607 (AAC/SGD eval first hour)	10 min	60 min	20 min	90 min
92608 (AAC/SGD add'l 30 min)	NA	NA	NA	30 min
92609 (AAC/SGD device tx)	10 min	60 min	10 min	80 min

Do you know about a resource you think we need to add to this FAQ?
Do you think we need to add clarification or fix errors on this document?
Get in touch with SCSHA today!