ASHA
American Speech-Language-Hearing Association

Calculating Medicare Fee Schedule Rates

The Medicare Physician Fee Schedule (MPFS) uses a resource-based relative value system (RBRVS) that assigns a relative value to current procedural terminology (CPT) codes that are developed and copyrighted by the American Medical Association (AMA) with input from representatives of health care professional associations and societies, including ASHA. The relative weighting factor (relative value unit or RVU) is derived from a resource-based relative value scale. The components of the RBRVS for each procedure are the (a) professional component (i.e., work as expressed in the amount of time, technical skill, physical effort, stress, and judgment for the procedure required of physicians and certain other practitioners); (b) technical component (i.e., the practice expense expressed in overhead costs such as assistant's time, equipment, supplies); and (c) professional liability component.

The Centers for Medicare and Medicaid Services (CMS) determines the final relative value unit (RVU) for each code, which is then multiplied by the annual conversion factor (a dollar amount) to yield the national average fee. Rates are adjusted according to geographic indices based on provider locality. Payers other than Medicare that adopt these relative values may apply a higher or lower conversion factor.

How Medicare Part B Fees are Calculated by Providers

There are many factors providers must take into account when calculating the final payment they will receive for Medicare Part B services.

- Standard 20% Co-Pay
- Non-Participating Status & Limiting Charge
- Facility & Non-Facility Rates
- Geographic Adjustments
- Multiple Procedure Payment Reductions (MPPR)

See also Medicare CPT coding rules for audiologists and speech-language pathologists .

Standard 20% Co-Pay

All Part B services require the patient to pay a 20% co-payment. The MPFS does not deduct the co-payment amount. Therefore, the actual payment by Medicare is 20% less than shown in the fee schedule. You must make "reasonable" efforts to collect the 20% co-payment from the beneficiary.

Non-Participating Status & Limiting Charge

There are two categories of participation within Medicare. Participating provider (who must accept assignment) and non-participating provider (who does not accept assignment). You may agree to be a participating provider (who does not accept assignment). Both categories require that providers enroll in the Medicare program.

You may agree to be a participating provider with Medicare. Once enrolled, you are required to bill on an assignment basis and accept the Medicare allowable fee as payment in full. Medicare will accept 80% of the allowable amount of the Medicare Physician Fee Schedule (MPFS) and the patient will pay a 20 % co-insurance at the time services are rendered or ask you to bill their Medicare supplemental policy. Both participating and non-participating providers are required to file the claim to Medicare.

As a non-participating provider you are permitted to decide on an individual claim basis whether or not to accept assignment or bill the patient on an unassigned basis. The allowable fee for a non-participating provider is reduced by five percent in comparison to a participating provider. Thus, if the allowable fee is $100 for a participating provider, the allowable fee for a non-participating provider is $95. Medicare will pay 80% of the $95. If assignment is accepted the patient is responsible for 20% of the $95. If assignment is not accepted, the patient will pay out of pocket for the service. In this case, the most the provider is permitted to charge the patient is 115% of the allowable fee. This is known as the limiting charge. Thus, using the example of the $95 allowable fee, the most you can charge the patient is $109.25 as long as the practitioner's standard fee is at least 15% above the MPFS fee.

Your status with Medicare may be changed by informing your contractor of your contracted status for the next calendar year, but only in November of the preceding year.

Facility & Non-Facility Rates

The MPFS includes both facility and non-facility rates. In general, if services are rendered in one's own office, the Medicare fee is higher (i.e., the non-facility rate) because the pratitioner is paying for overhead and equipment costs. Audiologists receive lower rates when services are rendered in a facility because the facility incurs overhead/equipment costs. Skilled nursing facilities are the most common applicable setting where facility rates for audiology services would apply because hospital outpatient departments are not paid under the MPFS.

Therapy services, such as speech-language pathology services, are allowed at non-facility rates in all settings (including facilities) because of a section in the Medicare statute permitting these services to receive non-facility rates regardless of the setting. ASHA asked CMS for clarification regarding audiology and CMS responded that the facility rate applied to all facility settings for audiology services.

Geographic Adjustments: Find Exact Rates Based on Locality

You may request a fee schedule adjusted for your geographic area from the Medicare Administrative Contractor (MAC) that processes your claims. You can also access the rates for geographic areas by going to the CMS Physician Fee Schedule Look-Up website. In general, urban states and areas have payment rates that are 5% to 10% above the national average. Likewise, rural states are lower than the national average.

The CMS Physician Fee Schedule Look-Up: A Step-by-Step Guide

Go to the CMS Physician Fee Schedule Look-Up website and select "Start Search". You will need to accept CMS' license agreement terms before proceeding.

To see payment rates in your area

- Select the year
- Select **Pricing Information**
- Choose your HCPCS (CPT code) criteria (single code, range of codes)
- Select **Specific Locality** or **Specific Medicare Administrative Contractor (MAC)**
- Enter the CPT code(s) you are looking for
- Under "Modifier" select **All Modifiers**
- Select your Locality (please note that they are not in alphabetical order)
- Results:
  - Non-Facility Price: Applies to audiology services provided in an office setting and *all* speech-language pathology services, regardless of setting.
  - Facility Price: Applies only to audiology services provided in a facility, such as a skilled nursing facility. Note that hospital outpatient audiology services are paid under the hospital outpatient payment

- The results can be printed, downloaded and saved, or e-mailed.

Providers may also use the CMS Physician Fee Schedule Look Up website to look up payment policy indicators relative value units and geographic practice cost indexes For detailed instructions go to How to Use the Searchable Medicare Physician Fee Schedule [PDF] on the CMS website.

Multiple Procedure Payment Reductions (MPPR)

Under the MPPR policy, Medicare reduces payment for the second and subsequent therapy, surgical, nuclear medicine, and advanced imaging procedures furnished to the same patient on the same day. Currently, no audiology procedures are affected by MPPR.

Therapy Services

MPPR is a per-day policy that applies across disciplines and across settings. For example, if an SLP and a physical therapist both provide treatment to the same patient on the same day, the MPPR applies to all codes billed that day, regardless of discipline. Under MPPR, full payment is made for the therapy service or unit with the highest practice expense value (MPFS reimbursement rates are based on professional work practice expense and malpractice components) and payment reductions will apply for any other therapy performed on the same day For the additional procedures provided on the same day the practice expense (i.e., support personnel time, supplies, equipment, and indirect costs) of each fee will be reduced by 50% (effective April 1, 2013) for Part B services in all settings. The professional work and malpractice expense components of the payment will not be affected. ASHA has developed three MPPR scenarios to illustrate how reductions are calculated.

MPPR primarily affects physical therapists and occupational therapists because they are professions that commonly bill multiple procedures or a timed procedure billed more than once per visit.

Speech Language Pathology Codes Subject to MPPR

- 92507 - Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
- 92508 - Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals
- 92521 - Evaluation of speech fluency (eg, stuttering, cluttering)
- 92522 - Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
- 92523 Evaluation of speech sound production (eg articulation phonological process apraxia dysarthria) **with** evaluation of language comprehension and expression (eg receptive and expressive language)
- 92524 - Behavioral and qualitative analysis of voice and resonance
- 92526 - Treatment of swallowing dysfunction and/or oral function for feeding
- 92597 - Evaluation for used and/or fitting of voice prosthetic device to supplement oral speech
- 92607 Evaluation for prescription for speech generating augmentative and alternative communication device face to face with the patient first hour
- 92609 - Therapeutic services for the use of speech-generating device, including programming and modification
- 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

See also MPPR Scenarios for Speech-Language Pathology Services