2020

Medicare Fee Schedule for Speech-Language Pathologists

ASHA
Speech-Language Pathology
Dedicated to Advancing the Profession of Speech-Language Pathology

General Information

The American Speech-Language-Hearing Association (ASHA) developed this document to provide an analysis of the 2020 Medicare Physician Fee Schedule (MPFS), including comments on relevant policy changes, a list of Current Procedural Terminology (CPT®) 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

Outpatient speech-language pathology services provided under Part B of the Medicare program are paid under the Medicare Physician Fee Schedule (MPFS). Congress approves annual payment updates to the MPFS. Starting in 2020, annual MPFS payment updates are frozen at 0.0% through 2025 because of a provision of the Medicare Access and CHIP Reauthorization Act of 2015. Additional payment adjustments—based on participation in Merit-Based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (AAPMs)—may also apply.

Rates associated with individual Current Procedural Terminology (CPT®) codes may continue to fluctuate due to adjustments to professional work, 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, 2020, for speech-language pathologists (SLPs) who provide services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include MIPS, new and updated CPT codes, and national payment rates for speech-language pathology-related services.

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 2020 Medicare Physician Fee Schedule (MPFS)

ASHA reviewed relevant sections of the 2020 MPFS final rule and offers the following analysis of key issues for SLPs.

Payment Rates

SLPs will generally see minor changes in 2020 payment 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 pathology codes.

ASHA's analysis of the MPFS revealed only small rate adjustments upwards or downwards for individual CPT codes, with a 0.40% total impact on national fee changes for speech-language pathology services. However, SLPs who provide cognitive therapy should be aware of a change to payment for cognitive function intervention, which is discussed in further detail in the new and updated CPT codes section (p. 4)

See Table 2 (p. 9) 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.

Conversion Factor (CF)

CMS uses the CF to calculate MPFS payment rates. CMS established a calendar year (CY) 2020 CF of **$36.0896**, which is slightly higher than the 2019 CF of $36.0391. This CF reflects the frozen annual payment update discussed in the overview as well as other mandated adjustments to maintain budget neutrality.

Relative Value Units

The value of each CPT code is calculated by separating the cost of providing the service into relative value units (RVUs) for three components—1) professional work, 2) practice expense (direct cost to provide the service), 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.

ASHA, through its Health Care Economics Committee, works with related specialty and physician groups to present data to the American Medical Association Relative Value Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC) to maintain and update the speech-language pathology code set and ensure the SLP's time and effort is appropriately captured in professional work. Professional work RVUs typically do not change over time, unlike practice expense values that fluctuate according to CMS payment formula policies. This effort is ongoing, and ASHA will continue to recommend professional work values for speech-language pathology services, as warranted. See ASHA's website for more information on the CPT code development and valuation process [PDF].

See Table 4 (p. 14) for a detailed chart of final 2020 RVUs.

Multiple Procedure Payment Reductions

The multiple procedure payment reduction (MPPR) policy for speech-language pathology and other services will continue in 2020. Under this system, per-code payment 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.

Potential Impact of Changes to Evaluation and Management (E/M) Codes on 2021 Payment Rates

In its release of the 2020 MPFS, CMS discussed changes to E/M coding and payment for CY 2021 and the projected impact of these changes on payment rates for Medicare providers. Due to the budget neutrality mandate for the Medicare program, CMS estimates a significant negative impact on many specialties. CMS did not provide a direct estimate of the potential impact for SLPs because of the relatively low number of SLPs enrolled as providers. However, SLPs have historically been included in the category of "Other" providers, which is projected for a 5% decrease, beginning in 2021. This number does not take into account other potential adjustments in 2021 and should be considered for illustrative purposes. ASHA is dismayed by the potential scale of the negative impact, given that SLPs do not currently have access to E/M services as part of their Medicare benefit category to help potentially offset the projected reductions in 2021. ASHA will work to determine the specific impact to SLPs and will actively engage with CMS, key decision-makers, and other specialty societies to seek a solution to the projected impact.

New and Updated CPT Codes

The 2020 MPFS includes values for new and revised CPT (Current Procedural Terminology ® American Medical Association) codes for pre- and post-implant evaluation of auditory function and computerized dynamic posturography. Additional details regarding the changes are available on ASHA's website and in *The ASHA Leader*.

Pre- and Post-Implant Auditory Function Evaluation

Starting in 2020, CPT code 92626 is revised to describe an evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); first hour. CPT code 92627—an add-on code—may be reported in conjunction with 92626 for each additional 15 minutes of the evaluation.

Although the code descriptions have changed to clearly describe their intended use, CMS will maintain the current values for CPT codes 92626 and 92627. ASHA worked with the American Academy of Audiology (AAA) to recommend these values to CMS, preventing potential reduction to payments for this evaluation.

Cognitive Function Intervention

CPT code 97127 (cognitive function intervention)—an untimed code—is deleted and replaced with two new timed codes: a base code for the initial 15 minutes of cognitive function intervention (97129) and an add-on code for each additional 15 minutes (97130). As with previous 15-minute timed codes for cognitive therapy (G0515 and 97532), these codes are subject to Medicare's "8-minute rule." This policy applies to timed codes billed in 15-minute units and is discussed in further detail in "The Right Time for Billing Codes".

Additionally, clinicians may not bill 97129 and 97130 on the same day as CPT 92507 (speech, language, voice, communication treatment) for Medicare Part B (outpatient) services. The National Correct Coding Initiative (NCCI) determines code pairs that may not be billed together on the same day, commonly referred to as CCI edits. The NCCI also develops medically unlikely edits (MUEs) that control how many units of a code may be billed on the same day.

CMS categorized CPT codes 97129 and 97130 as "sometimes therapy" codes. This categorization means that SLPs must include the "GN" modifier on claims with these codes to indicate that the services were provided under a speech-language pathology plan of care. However, these codes will *not* be subject to MPPR. Medicare's MPPR policy applies only to CPT codes categorized as "always therapy."

CMS also confirmed that G0515—Medicare's current 15-minute code for cognitive skills development—will be deleted, effective January 1. This ensures a single coding option for cognitive treatment across payers in 2020.

ASHA worked with the American Psychological Association (APA) to develop the new codes and submit value recommendations to CMS. CMS accepted ASHA's recommendations and will implement the new codes in the 2020 MPFS. However, due to decreases to practice expense values, which reflect the direct cost of providing each service, SLPs should be prepared to see payment reductions of approximately 30% for cognitive therapy beginning in 2020.

Online Assessment by Qualified Nonphysician Health Care Professional (E-Visit)

CMS had proposed three new Medicare G-codes (G2061-G2063) that describe non-face-to-face, patient-initiated online assessments for use by qualified nonphysician health care professionals but did not provide additional guidance regarding reporting requirements or eligible providers. ASHA commented in support of implementation of the e-visit codes and urged CMS to allow SLPs to report and receive payment for e-visits under the MPFS. However, CMS did not accept the recommendation and clarified in the final rule that these codes are outside the Medicare benefit category for most nonphysician specialty groups—including SLPs—and cannot be reported for Part B beneficiaries. As such, they are not included in the 2020 MPFS for SLPs.

Repeal of the Therapy Caps

The Bipartisan Budget Act of 2018 permanently repealed the hard therapy cap and exceptions process. However, it maintained the two key financial thresholds for therapy services—the "KX" modifier threshold and the medical review threshold. Once a patient exceeds the "KX" modifier threshold, the SLP should append the "KX" modifier to claims to attest to medical necessity of services. The "KX" modifier threshold is $2,080 in 2020 for speech-language pathology and physical therapy services combined. The use of the "KX" modifier is also required above the medical review threshold, but records will only be requested if the clinician meets certain criteria, such as aberrant billing patterns or high utilization. The medical review threshold will remain at $3,000, for speech-language pathology and physical therapy services combined, until 2028, at which time it will be updated annually, just like the "KX" modifier threshold.

The thresholds reset annually on January 1 and apply to all outpatient therapy services a Medicare beneficiary receives throughout the course of the calendar year, regardless of practice setting or diagnosis. There are no additional criteria or requirements, with the exception of the requirement to use the "KX" modifier, when services exceed these thresholds. Services must always be medically necessary, require the skills of the SLP, and be designed to improve or maintain function for the patient. More

information about the thresholds and the targeted medical review process is available on the ASHA website.

The Quality Payment Program (QPP)

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established the Quality Payment Program (QPP). The QPP is comprised of two tracks—MIPS and AAPMs. Medicare modifies payment for outpatient services based on QPP participation. More information on the QPP can be found on the ASHA website.

Merit-Based Incentive Payment System (MIPS)

SLPs first became eligible for MIPS for 2019 and will continue to participate in the program in 2020. If an SLP meets the criteria for a MIPS eligible clinician (EC), they will need to report data associated with quality measures and improvement activities in 2020 that will be used to adjust their payments in 2022.

Since CMS has set exclusions and low-volume thresholds, a large majority of SLPs will be excluded from MIPS participation for 2020. MIPS only applies to clinicians in outpatient non-facility settings. In addition, clinicians must meet **ALL** of the following criteria to be required to participate:

- $90,000 or more allowed charges to the Medicare program for professional services; and
- treat 200 or more distinct Medicare beneficiaries; and
- provide 200 or more distinct procedures.

For eligible participants, a payment incentive or penalty will be applied to 2022 Medicare payments for performance on the quality and improvement activities (IAs) performance categories in 2020.

Clinicians meeting one or two of the criteria may opt-in to the program to compete for payment adjustments while others—who do not meet any of the criteria—may voluntarily report to gain experience. Required participants who choose not to report will be subject to the maximum payment reduction of 9% for the year.

For the quality performance category, MIPS eligible clinicians—including SLPs—must report a minimum of six measures when/if six measures apply. Currently, SLPs have three potentially applicable measures. CMS added two new measures and eliminated one measure from MIPS entirely (Measure 131: Pain Assessment and Follow-Up), leaving SLPs with four measures in the specialty measure set for the 2020 performance/2022 payment year, as outlined below.

- Measure 130: Documentation of Current Medications in the Medical Record
- Measure 181: Elder Maltreatment Screen and Follow-Up Plan (**new**)
- Measure 182: Functional Outcome Assessment (**new**)
- Measure 226: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention

This means that SLPs must report all four measures whenever applicable; since there are only four possible measures SLPs will *not* be penalized for reporting on fewer than six measures. See ASHA's website for additional details and ongoing updates regarding MIPS.

Advanced Alternative Payment Models (AAPMs)

AAPMs are Medicare approaches that incentivize quality and value. AAPMs take a variety of forms, including accountable care organizations, patient-centered medical homes, bundled payments, and episodes of care. SLPs **have been able** to participate in the AAPM option since 2017. Those who successfully participate in 2020 will be eligible to receive a 5% lump-sum incentive payment on their Part B services in 2022. An example of an AAPM is the Medicare Shared Savings Program ACO-Track 2.

CMS decides which clinicians will be considered participants in an AAPM based on the Tax Identification Number for the group of clinicians. If the entire group of clinicians meets the threshold amount at any point during the performance period (Jan. 1–Aug. 31), all of the clinicians will receive the bonus payment attributed to their National Provider Identification numbers.

For example, in performance year 2020, an SLP can qualify as a participant in an AAPM and receive the 5% incentive payment in 2022—if at least 25% of the group's Medicare payments or at least 20% of the group's Medicare patients receive services through the AAPM.

To allow more clinicians to qualify for the incentive payment, CMS began in performance year 2019 to also include other payers like Medicaid, private insurance and Medicare Advantage payments, and patient counts in the thresholds. For example, if 50% of the group's total payer payments or at least 35% of the AAPM's total patient counts receive services through the AAPM, the clinicians would be eligible for the 5% incentive payment in 2022.

2020 Medicare Physician Fee Schedule for Speech-Language Pathology Services

Table 1. Topical List of Codes

This table displays 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 practice areas.

Speech & Language		Physical Medicine & Rehabilitation	Dysphagia (Including Instrumental Assessments)	Other Instrumental/ Radiologic Assessments
92507	92609	97129	92526	31575
92508	92618	97130	92610	31579
92520	92626	97533	92611	70371
92521	92627	97535	92612	74230
92522	92630		92613	76536
92523	92633		92614	92511
92524	96105		92615	
92597	96110		92616	
92605	96112		92617	
92606	96113			
92607	96125			
92608				

Table 2. National Medicare Part B Rates for Speech-Language Pathology Services

The following table contains full descriptors and national payment rates for speech-language pathology-related services. Calculations were made using the 2020 CF (**$36.0896**). Please see ASHA's Outpatient MPFS website for other important information, including Medicare fee calculations and how to find rates by locality.

Medicare pays for speech-language pathology services at non-facility rates, regardless of setting. All claims should be accompanied by the "GN" modifier to indicate services are provided under a speech-language pathology plan of care. Please see ASHA's Medicare CPT Coding Rules for Speech-Language Pathology Services for additional coding guidance.

CPT Code	Descriptor	2020 National Fee	Notes
31579	Laryngoscopy, flexible or rigid telescopic; with stroboscopy	**$197.05**	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	**$81.20**	
92508	group, 2 or more individuals	**$24.54**	
92511	Nasopharyngoscopy with endoscope (separate procedure)	**$114.76**	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)	**$60.99**	
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	**$82.28**	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	**$115.85**	
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	**$94.55**	Do not bill 92522 in conjunction with 92523.
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	**$198.49**	Do not bill 92523 in conjunction with 92522.
92524	Behavioral and qualitative analysis of voice and resonance	**$92.39**	This procedure does not include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding	**$89.50**	

CPT Code	Descriptor	2020 National Fee	Notes
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	**$75.07**	
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.
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	**$132.09**	
92608	each additional 30 minutes (List separately in addition to code for primary procedure)	**$53.05**	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	**$111.16**	
92610	Evaluation of oral and pharyngeal swallowing function	**$89.14**	
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	**$94.55**	
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;	**$203.55**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
92613	interpretation and report only	**$38.98**	This CPT code may be reported when the SLP has not performed the endoscopic evaluation but is asked to interpret the report. The SLP should not use this code if they perform 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;	**$152.30**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.

CPT Code	Descriptor	2020 National Fee	Notes
92615	interpretation and report only	**$34.29**	This CPT code may be reported when the SLP has not performed the endoscopic evaluation but is asked to interpret the report. The SLP should not use this code if they perform 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;	**$221.59**	This procedure may require physician supervision based on MACs' local coverage policies or state practice acts.
92617	interpretation and report only	**$42.59**	This CPT code may be reported when the SLP has not performed the endoscopic evaluation but is asked to interpret the report. The SLP should not use this code if they perform the endoscopy. Use of this code may be limited based on MACs' local coverage policies.
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	**$92.39**	**Revised in 2020.** This code may be used by SLPs to report an evaluation of auditory function related to pre-implant candidacy or post-implant status evaluation. See also: New and Updated CPT Codes for 2020
92627	each additional 15 minutes (List separately in addition to code for primary procedure)	**$22.01**	This is an add-on code for 92626.
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	**$105.74**	
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.

CPT Code	Descriptor	2020 National Fee	Notes
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	**$140.39**	
96113	each additional 30 minutes (List separately in addition to code for primary procedure)	**$62.80**	
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	**$111.88**	See also: Coding and Reimbursement of Cognitive Evaluation and Treatment Services
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	**$24.54**	**New in 2020.** 97129 and add-on code 97130 replace G0515. Use to report the initial 15 minutes of therapy. See also: New and Updated CPT Codes for 2020 and Coding and Reimbursement of Cognitive Evaluation and Treatment Services
97130	each additional 15 minutes (List separately in addition to code for primary procedure)	**$23.46**	**New in 2020.** This is an add-on code to report in conjunction with 97129 for each additional 15 minutes of therapy.
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	**$53.05**	Except for 97129/97130, SLPs' appropriate use of the Physical Medicine & Rehabilitation (PMR) 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	**$35.01**	Except for 97129/97130, SLPs' appropriate use of the PMR series codes should be verified with the MAC.

CPT Code	Descriptor	2020 National Fee	Notes
G0451	Developmental testing, with interpretation and report, per standardized instrument form	**$10.11**	This Medicare-specific HCPCS Level II code can be used in place of CPT 96110, which is not paid by Medicare.
G0515	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	**$0.00**	**Deleted in 2020.** See 97129 (p. 12) for cognitive treatment.

Table 3. National Medicare Part B Rates for Other CPT Codes of Interest to Speech-Language Pathologists

The procedures in this table are for informational purposes and are not for billing by SLPs.

CPT Code	Descriptor	2020 National Fee	Notes
31575	Laryngoscopy, flexible; diagnostic	**$125.95**	This procedure is for medical diagnosis by a physician.
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	**$109.35**	This is a radiology code.
74230	Swallowing function, with cineradiography/videoradiography	**$131.37**	This is a radiology code.
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	**$118.01**	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, as listed in Table 2 (p. 9). For geographically-adjusted RVUs, go to Addenda E in the CMS CY 2020 PFS Final Rule Addenda [ZIP] files.

CPT Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
31579	1.88	3.32	0.26	5.46
92507	1.30	0.90	0.05	2.25
92508	0.33	0.34	0.01	0.68
92511	0.61	2.52	0.05	3.18
92512	0.55	1.09	0.05	1.69
92520	0.75	1.48	0.05	2.28
92521	1.75	1.38	0.08	3.21
92522	1.50	1.04	0.08	2.62
92523	3.00	2.39	0.11	5.50
92524	1.50	0.98	0.08	2.56
92526	1.34	1.09	0.05	2.48
92597	1.26	0.76	0.06	2.08
92607	1.85	1.73	0.08	3.66
92608	0.70	0.74	0.03	1.47
92609	1.50	1.52	0.06	3.08
92610	1.30	1.11	0.06	2.47
92611	1.34	1.19	0.09	2.62
92612	1.27	4.30	0.07	5.64
92613	0.71	0.32	0.05	1.08
92614	1.27	2.86	0.09	4.22
92615	0.63	0.27	0.05	0.95
92616	1.88	4.15	0.11	6.14
92617	0.79	0.34	0.05	1.18
92626	1.40	1.11	0.05	2.56
92627	0.33	0.27	0.01	0.61
96105	1.75	1.09	0.09	2.93
96112	2.56	1.20	0.13	3.89
92613	1.16	0.52	0.06	1.74
96125	1.70	1.32	0.08	3.10
97129	0.50	0.16	0.02	0.68
97130	0.48	0.15	0.02	0.65
97533	0.48	0.97	0.02	1.47
97535	0.45	0.50	0.02	0.97
G0451	0.00	0.27	0.01	0.28

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