2023

Medicare Fee Schedule for Speech-Language Pathologists

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

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General Information

The American Speech-Language-Hearing Association (ASHA) developed this document to provide an analysis of the 2023 Medicare Physician Fee Schedule (MPFS), including comments on relevant policy changes, a list of Current Procedural Terminology (CPT® American Medical Association) codes used by speech-language pathologists (SLPs) with their national average payment amounts, and useful links to additional information.

SLPs should always contact their local Medicare Administrative Contractor for final rates and coverage guidelines.

ASHA's Medicare outpatient payment website provides additional information regarding the MPFS, including background information, how providers should calculate Medicare payment, and speech-language pathology specific payment and coding rules. If you have any 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, which are frozen at 0.0% from 2020 through 2025 because of a provision in the Medicare Access and CHIP Reauthorization Act of 2015. Additional payment adjustments—based on legislative actions, participation in the Merit-Based Incentive Payment System (MIPS), or Advanced Alternative Payment Models (APMs)—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. In addition, 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, 2023, for speech-language pathologists (SLPs) who provide services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include coding updates; quality reporting; APMs; and national payment rates for speech-language pathology related services.

ASHA's Medicare outpatient payment resources provide additional information on the MPFS, including background information, instructions for calculating Medicare payment, and speech-language pathology payment and coding rules. If you have any questions, please contact reimbursement@asha.org.

Analysis of the 2023 Medicare Physician Fee Schedule (MPFS)

ASHA reviewed relevant sections of the 2023 MPFS final rule and offers the following analysis of key issues for SLPs.

Payment Rates

Significant payment cuts to all services provided under the MPFS are set to return in 2023. These cuts would have also gone into effect in 2021 and 2022 due to changes in payment for outpatient office-based evaluation and management (E/M) services and adjustments to the annual conversion factor. Although advocacy by ASHA and other stakeholders resulted in legislation that mitigated the cuts each year, the positive adjustment will expire at the end of 2022, meaning that SLPs will continue to face significant cuts without additional intervention from Congress.

ASHA continues working with allied stakeholders to convince Congress to address the cuts with a positive adjustment to 2023 Medicare payments and to make fundamental long-term changes to the Medicare payment system. However, SLPs should be prepared for the cuts to go into effect on January 1 if Congress does not pass a legislative fix before the end of the year. Bipartisan legislation, the Supporting Medicare Providers Act of 2022 (H.R. 8800), has been recently introduced by Representatives Ami Bera (D-CA) and Larry Buchson (R-IN) to mitigate cuts in 2023. ASHA strongly encourages SLPs to contact their members of Congress and ask them to both cosponsor H.R. 8800 and address the Medicare cuts before the end of the year.

Conversion Factor (CF)

CMS uses the CF to calculate MPFS payment rates. CMS established a calendar year (CY) 2023 CF of **$33.06**, representing a 4.5% decrease from the $34.61 CF for 2022, due in large part to the expiration of the 3% positive payment adjustment Congress implemented to mitigate the cuts in 2022.

Payment Changes to Speech-Language Pathology Services

CMS's regulatory impact analysis (RIA) of the final rule estimates that speech-language pathology services will see a cumulative negative 1% change in payments. The analysis also shows that most

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individual SLPs will experience between a negative 2% to a positive 1% shift in reimbursement in 2023 in *addition* to the cut of the CF.

Medicare providers also face other Medicare cuts known as sequestration (2% reduction) and statutory "Pay-As-You-Go", or PAYGO, (4% reduction). This could result in a total cut of over 10% to overall Medicare payments when added to the MPFS payment cuts. Congress acted in 2021 and 2022 by passing legislation that significantly reduced some of the cuts and phased in the remaining cuts over the course of 2022.

It is important to note that the estimated impacts calculated by CMS reflect average payments based on cumulative therapy spending under the MPFS. However, it may not reflect the changes experienced by individual SLPs or practices, as actual payment depends on several factors, including locality-specific rates and the CPT codes billed. For example, CPT code 92507 (speech, language, communication treatment) will see a 4% decrease to the national payment rate while CPT code 92612 (flexible endoscopic evaluation of swallowing) will experience a 2% decrease. As a result, SLPs wishing to determine the actual impact of the payment changes to their practice should calculate payments based on their specific billing patterns and locality.

See Table 1 (p. 9) for a listing of speech-language pathology procedures and corresponding national payment rates. The table also includes 2022 non-facility rates for comparison with 2023 rates to help SLPs estimate the impact of the payment cuts. Visit ASHA's webpage on calculating Medicare fee schedule rates for information on how to access fees based on locality.

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 of the qualified health care professional;
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 CPT code is multiplied by the CF to determine the corresponding fee. **See Table 3 (p. 17)** for a detailed chart of final 2023 RVUs.

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 rarely change over time, unlike practice expense values that fluctuate according to CMS payment formula policies. ASHA will continue to recommend professional work values for speech-language pathology services, as warranted. See ASHA's infographic for more information on the CPT code development and valuation process [PDF].

Multiple Procedure Payment Reductions (MPPR)

The MPPR policy for speech-language pathology and other services will continue in 2023. Under this system, per-code payment is decreased when multiple codes are performed for a single beneficiary on 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.

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CPT Code Updates

The final rule implements the following CPT code changes in the 2023 MPFS. ASHA's website provides more information on 2023 coding updates.

Remote Therapeutic Monitoring (RTM) Services

CMS adds a new code to the existing family of RTM services to reflect the supplies for monitoring devices related to cognitive behavioral therapy (CBT), as follows.

98978: Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days

Although CPT code 98978 is included under the 2023 MPFS, it was not assigned a specific value and will be contractor priced. SLPs should verify coverage and billing for this new code with their local Medicare administrative contractor and other non-Medicare payers.

See Table 1 (p. 9) for the final national payment rates for RTM services. ASHA's website provides more information on how to use the RTM codes.

Virtual Reality (VR) Technology for Therapy

A new Category III CPT code for VR technology will also be effective January 1, 2023, as follows.

- **0770T:** Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)

0770T is an add-on code for those times when VR technology is used as a tool of therapy and may only be reported in conjunction with a limited list of therapy CPT codes, including 92507 and 92508. ASHA's website provides a full list of codes 0770T may be reported with.

0770T is **not** included under the MPFS because Category III CPT codes represent new technology and are priced and covered at the discretion of the local Medicare administrative contractors. SLPs should verify coverage and billing for this new code with their local Medicare administrative contractor and other non-Medicare payers.

Targeted Manual Medical Review

CMS notes in the final rule that the Bipartisan Budget Act of 2018 permanently repealed the hard caps on therapy services and permanently extended the targeted medical review process first applied in 2015. Therefore, Medicare beneficiaries can continue to receive medically necessary treatment with no arbitrary payment limitations. The threshold that triggers potential medical review is $3,000 for speech-language pathology and physical therapy combined. There is also a "KX" modifier threshold, at which point clinicians must report the "KX" modifier on the claim to demonstrate continued medical need for services. The KX modifier threshold for 2023 is **$2,230** for physical therapy and speech-language pathology services, combined. ASHA's website provides more information regarding the permanent repeal of the cap and the targeted manual medical review process.

Medicare Telehealth Services

CMS lacks the statutory authority to maintain the telehealth flexibilities allowed during the federal public health emergency (PHE), so SLPs will no longer receive Medicare reimbursement for telehealth services when the PHE and the 151-day extension expire. However, the final rule includes ongoing coverage of several CPT codes used by SLPs through the end of 2023, as listed on ASHA's website (see also, Table 12 of the final rule). This means that these codes will continue to be payable through 2023—even if the PHE and extension expire earlier—but only when provided by a physician or practitioner or by an SLP providing services incident-to such a provider. Please monitor ASHA's advocacy news for updates on significant changes to the federally declared PHE.

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ASHA is committed to advocating for permanent Congressional authority for SLPs and audiologists to be telehealth providers under Medicare.

Implementation of Telehealth Provisions for 151 Days After the End of the PHE

The Consolidated Appropriations Act extended certain Medicare telehealth flexibilities adopted during the PHE for 151 days after the federal COVID-19 PHE expires. In the final rule, CMS confirms that during the 151-day extension, it will continue the same flexibilities, which will help minimize provider and Medicare contractor burden and ensure continued beneficiary access to telehealth services across geographic areas; in a broad range of settings (including the patient's home); and from a wide array of providers, including SLPs.

Of note, CMS will still require providers to include modifier "95" on claims for Part B telehealth services furnished on or before the 151st day after the federal PHE expires, in alignment with policies related to the current telehealth flexibilities. CMS will also continue to allow Part B providers to use the place of service (POS) code that best reflects where the services would have normally been furnished in person. For example, a clinician in a private practice providing telehealth services to a patient at home could report POS 11 (office) because that's where they would have provided in-person services.

See ASHA's website for additional details about Medicare's telehealth coverage during and after the PHE.

The Quality Payment Program (QPP)

The QPP transitions Medicare payments away from a volume-based fee-for-service payment to a more value-based system of quality and outcomes-based reimbursement. The program includes the Merit-Based Incentive Payment System and Advanced Alternative Payment Models. ASHA's website provides more information on the QPP.

Merit-Based Incentive Payment System (MIPS)

MIPS represents one track of the QPP that focuses on quality improvement in fee-for-service Medicare. SLPs first became eligible for MIPS for 2019 and will continue to participate in the program in 2023. 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 2023, which will be used to adjust their payments in 2025.

Because CMS has set exclusions and low-volume thresholds, a large majority of SLPs will be excluded from mandatory MIPS participation for 2023. 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 participants subject to mandatory reporting, CMS will apply a payment incentive or penalty to 2025 Medicare payments for performance on the quality and improvement activities (IAs) performance categories in 2023. 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. In 2023, SLPs have five applicable measures. This means that SLPs must report all five measures whenever applicable. ASHA's website provides additional details and ongoing updates regarding MIPS.

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- Measure 130: Documentation of Current Medications in the Medical Record
- Measure 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Measure 181: Elder Maltreatment Screen and Follow-Up Plan
- Measure 182: Functional Outcome Assessment
- Measure 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

For the IA performance category, SLPs must score a minimum of 40 points and attest to their completion via the CMS QPP website. See Appendix 2 of the final rule for a full list of IAs.

Advanced Alternative Payment Models (APMs)

APMs, the second track and a key initiative within the QPP, incentivize quality and value. SLPs may participate in the Advanced APM option in 2023. Those who successfully participate will receive a 5% lump-sum incentive payment on their Part B services in 2025. For performance year 2023, the Medicare-Only payment threshold is 75% and the patient count threshold is 50%. Therefore, at least 75% of your Medicare Part B payments or at least 50% of your Medicare patients must be seen through an Advanced APM entity. Under the All-Payer Combination Option, you must first meet certain threshold percentages under the Medicare Option, which is 50% for the payment amount method or 35% under the patient count method. These thresholds are designed to measure whether the provider is actively taking steps to increase their participation in value-based care arrangements.

Determination of the Advanced APM 5% bonus takes place at the facility/APM entity level (Tax Identification Number or TIN) or at the individual eligible clinical level. CMS is requesting feedback on the idea of calculating threshold scores and making qualified provider determinations exclusively at the individual, rather than APM entity level, in the future.

Additional changes have been made for 2023 with the aim to jumpstart enrollment in accountable care organizations (ACOs) and make them more accurate and equitable.

To address the need for upfront capital to succeed in accountable care, shared savings payments (referred to as advance investment payments) will be available to low revenue ACOs inexperienced with performance-based risk Medicare ACO initiatives, those that are new to the Shared Savings Program, and those that serve underserved populations.

To ease the transitions from fee-for-service to value-based care, CMS will allow ACOs inexperienced with the performance-based risk model to participate in a one-sided shared savings model for 5-7 years. This means that ACOs can be rewarded for providing high-quality, cost-effective care without financial risk for the first 5-7 years.

Other changes include:

- retooling the benchmarking system to encourage long-term participation in the program,
- modifying the risk adjustment methodology to more accurately account for medically complex and high-cost patients, and
- providing a health equity adjustment of up to 10 bonus points to an ACO's quality performance category score will be available for certain participants.

For performance year 2023, ACOs will be required to report either the 10 measures under the CMS Web Interface:

- Quality ID# 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- Quality ID # 134 Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Quality ID # 370 Depression Remission at Twelve Months
- Quality ID # 318 Falls: Screening for Future Fall Risk
- Quality ID # 438 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

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- Quality ID # 110 Preventive Care and Screening: Influenza Immunization
- Quality ID # 112 Breast Cancer Screening
- Quality ID # 113 Colorectal Cancer Screening
- Quality ID # 226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Quality ID # 236 Controlling High Blood Pressure

or the three electronic clinical quality measures (eCQMs) /MIPS CQMs:

- CMS eCQM ID: CMS122v11 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- CMS eCQM ID: CMS2v12 Depression Screening and Follow-Up
- CMS eCQM ID: CMS165v11 Controlling High Blood Pressure

and administer the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS survey.

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2023 Medicare Physician Fee Schedule for Speech-Language Pathology Services

Table 1. 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. ASHA calculated rates by multiplying the total RVUs for each CPT code by the 2023 CF (**$33.06**). The table also includes 2022 non-facility rates for comparison with 2023 rates to help SLPs estimate the impact of the payment cuts. Please see ASHA's Medicare outpatient payment website for other important information, including Medicare fee calculations and how to find rates by locality.

Medicare pays for outpatient 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.

Code	Descriptor	2022 National Fee	2023 National Fee	Notes
31579	Laryngoscopy, flexible or rigid telescopic; with stroboscopy	$204.52	**$197.37**	This procedure may require physician supervision based on your Medicare Administrative Contractor's (MAC's) local coverage policy or state practice act. See ASHA's website for more information.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	$78.21	**$75.38**	SLPs may also use 92507 to report auditory (aural) rehabilitation.
92508	group, 2 or more individuals	$24.22	**$23.47**	See also: Medicare Guidelines for Group Therapy and Modes of Service Delivery for Speech-Language Pathology
92511	Nasopharyngoscopy with endoscope (separate procedure)	$122.16	**$117.03**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act. See ASHA's website for more information.
92512	Nasal function studies (eg, rhinomanometry)	$63.68	**$62.48**	
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	$84.09	**$83.97**	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	$135.66	**$130.92**	
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	$113.85	**$109.43**	Don't bill 92522 in conjunction with 92523.

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Code	Descriptor	2022 National Fee	2023 National Fee	Notes
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	$231.52	**$224.48**	Don't bill 92523 in conjunction with 92522.
92524	Behavioral and qualitative analysis of voice and resonance	$112.12	**$108.11**	This procedure doesn't include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding	$86.86	**$83.64**	See also: Answers to Your Feeding/Swallowing Coding Questions
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	$73.71	**$70.75**	
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	$126.66	**$121.99**	See also: Billing for AAC and Device Documentation
92608	each additional 30 minutes (List separately in addition to code for primary procedure)	$50.18	**$47.94**	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	$106.24	**$101.83**	See also: Billing for AAC and Device Documentation
92610	Evaluation of oral and pharyngeal swallowing function	$87.21	**$83.64**	See also: Answers to Your Feeding/Swallowing Coding Questions
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	$93.78	**$90.26**	92611 reflects the SLP's work during the study. Radiologists separately report 74230 (see Table 2) to report their participation in the study. See also: Answers to Your Feeding/Swallowing Coding Questions
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;	$198.64	**$194.40**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act. See also: Answers to Your Feeding/Swallowing Coding Questions
92613	interpretation and report only	$37.03	**$36.37**	SLPs may report 92613 when you haven't performed the endoscopic evaluation but are asked to review and interpret the study. Don't use this code if you also perform the endoscopy. MACs may limit use of this code based on their local coverage policies.

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Code	Descriptor	2022 National Fee	2023 National Fee	Notes
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	$149.50	**$145.14**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act.
92615	interpretation and report only	$33.22	**$32.07**	SLPs may report 92615 when you haven't performed the endoscopic evaluation but are asked to review and interpret the study. Don't use this code if you also perform the endoscopy. MACs may limit use of this code based on their local coverage policies.
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;	$221.13	**$221.51**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act.
92617	interpretation and report only	$41.53	**$40.00**	SLPs may report 92617 when you haven't performed the endoscopic evaluation but are asked to review and interpret the study. Don't use this code if you also perform the endoscopy. MACs may limit use of this code based on their 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	$89.98	**$85.63**	See also: Dos and Don'ts for Revised Implant-Related Auditory Function Evaluation CPT Codes
92627	each additional 15 minutes (List separately in addition to code for primary procedure)	$21.11	**$20.17**	This is an add-on code to report in conjunction with 92626 for each additional 15 minutes of evaluation.
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	$100.01	**$95.88**	

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Code	Descriptor	2022 National Fee	2023 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	$129.08	**$123.65**	
96113	each additional 30 minutes (List separately in addition to code for primary procedure)	$60.91	**$58.52**	
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	$105.89	**$100.84**	See also: Coding and Payment 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	$23.19	**$22.15**	See also: Coding and Payment of Cognitive Evaluation and Treatment Services
97130	each additional 15 minutes (List separately in addition to code for primary procedure)	$22.49	**$21.16**	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	$66.10	**$62.82**	SLPs should verify use of the Physical Medicine & Rehabilitation (PMR) series of codes with the MAC, with the exception of 97129 and 97130. See also: Use of Physical Medicine Codes

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Code	Descriptor	2022 National Fee	2023 National Fee	Notes
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	$33.57	**$32.40**	SLPs should verify use of the PMR series of codes with the MAC, with the exception of 97129 and 97130. See also: Use of Physical Medicine Codes
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	$11.77	**$11.24**	See also: Use of CTBS Codes During COVID-19
98971	11-20 minutes	$20.76	**$19.84**	
98972	21 or more minutes	$32.18	**$30.42**	
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment	$19.38	**$18.84**	See also: Use of CTBS Codes During COVID-19
98976	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	$55.72	**$48.93**	
98977	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	$55.72	**$48.93**	
98978	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	N/A	**MAC priced**	**New in 2023.** See also: Speech-Language Pathology CPT and HCPCS Code Changes for 2023 and Use of CTBS Codes During COVID-19

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Code	Descriptor	2022 National Fee	2023 National Fee	Notes
98980	Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes	$50.18	**$48.27**	See also: Use of CTBS Codes During COVID-19 98981 is the add-on code to report in conjunction with 98980 for each additional 20 minutes of RTM treatment services during the calendar month.
98981	each additional 20 minutes (listed separately in addition to code for primary procedure)	$40.84	**$38.68**	
G0451	Developmental testing, with interpretation and report, per standardized instrument form	$10.73	**$10.58**	This Medicare-specific HCPCS Level II code can be used in place of CPT 96110, which isn't paid by Medicare.
G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment	$12.11	**$11.90**	See also: Use of CTBS Codes During COVID-19
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	$14.53	**$13.89**	See also: Use of CTBS Codes During COVID-19
92700	Unlisted otorhinolaryngological service or procedure	MAC priced	**MAC priced**	Report 92700 for a covered Medicare service that does not have a corresponding CPT code. See also: New Procedures...But No Code

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Table 2. National Medicare Part B Rates for Non-Benefit Services or Other CPT Codes of Interest

SLPs may not directly bill Medicare for the following procedures, which are listed for informational purposes only. Although some of these procedures are within the scope of practice of an ASHA-certified SLP, some services—such as screenings—are specifically excluded from the Medicare benefit or are not recognized for billing when performed by an SLP. Rates are included for reference only, when available. Please see Table 1 (p. 9) for services and procedures SLPs may bill directly to Medicare.

Code	Descriptor	2023 National Fee	Notes
31575	Laryngoscopy, flexible; diagnostic	**$128.94**	This procedure is for medical diagnosis by a physician.
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	**$107.45**	This is a radiology code.
74230	Swallowing function, with cineradiography/videoradiography	**$126.29**	This is a radiology code. See CPT code **92611** for the appropriate speech-language pathology procedure.
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	**$110.75**	This is a radiology code.
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	**$89.59**	CMS won't pay for this code because it is considered bundled with any other speech-language pathology service provided on the same day. SLPs may not separately bill for non-speech-generating device services alone.
92618*	each additional 30 minutes (List separately in addition to code for primary procedure)	**$31.41**	*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	**$78.02**	CMS won't pay for this code because it is considered a bundled service included in other speech-language pathology services provided on the same day. SLPs may not separately bill for non-speech-generating device services alone.
92630	Auditory rehabilitation; prelingual hearing loss	**$0.00**	This is a non-payable code. However, auditory (aural) rehabilitation is a covered Medicare benefit, so CMS instructs SLPs to use **92507** instead.
92633	postlingual hearing loss	**$0.00**	This is a non-payable code. However, auditory (aural) rehabilitation is a covered Medicare benefit, so CMS instructs SLPs to use **92507** instead.

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Code	Descriptor	2023 National Fee	Notes
96110	Developmental screening, with interpretation and report, per standardized instrument form	**$10.58**	Medicare does not pay for screenings. See HCPCS code **G0451** for developmental testing using a standardized instrument form.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	**$29.09**	This is a PMR code. CMS won't pay for this code when reported by an SLP. See also: Use of Physical Medicine Codes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	**$33.39**	This is a PMR code. CMS won't pay for this code when reported by an SLP. See also: Use of Physical Medicine Codes
97150	Therapeutic procedure(s), group (2 or more individuals)	**$17.52**	This is a PMR code. Generally, CMS won't pay for this code when reported by an SLP. However, some MACs may allow SLPs to report 97150 for group therapy for conditions not covered under 92508, such as cognition or dysphagia. See also: Medicare Guidelines for Group Therapy and Modes of Service Delivery for Speech-Language Pathology
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	**$36.70**	This is a PMR code. CMS won't pay for this code when reported by an SLP. See also: Use of Physical Medicine Codes
G2252		**$26.12**	CMS won't pay for this code when reported by an SLP.

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Table 3. 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 1 (p. 9). For geographically adjusted RVUs, go to Addendum E in the CMS CY 2023 PFS Final Rule Addenda [ZIP] files.

Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
31579	1.88	3.84	0.25	5.97
92507	1.30	0.94	0.04	2.28
92508	0.33	0.37	0.01	0.71
92511	0.61	2.89	0.04	3.54
92512	0.55	1.30	0.04	1.89
92520	0.75	1.75	0.04	2.54
92521	2.24	1.66	0.06	3.96
92522	1.92	1.32	0.07	3.31
92523	3.84	2.85	0.10	6.79
92524	1.92	1.28	0.07	3.27
92526	1.34	1.15	0.04	2.53
92597	1.26	0.84	0.04	2.14
92607	1.85	1.80	0.04	3.69
92608	0.70	0.73	0.02	1.45
92609	1.50	1.54	0.04	3.08
92610	1.30	1.19	0.04	2.53
92611	1.34	1.31	0.08	2.73
92612	1.27	4.55	0.06	5.88
92613	0.71	0.34	0.05	1.10
92614	1.27	3.05	0.07	4.39
92615	0.63	0.30	0.04	0.97
92616	1.88	4.72	0.10	6.70
92617	0.79	0.38	0.04	1.21
92626	1.40	1.15	0.04	2.59
92627	0.33	0.27	0.01	0.61
96105	1.75	1.05	0.10	2.90
96112	2.56	1.04	0.14	3.74
96113	1.16	0.55	0.06	1.77
96125	1.70	1.29	0.06	3.05
97129	0.50	0.16	0.01	0.67
97130	0.48	0.15	0.01	0.64
97533	0.48	1.41	0.01	1.90
97535	0.45	0.52	0.01	0.98
98970	0.25	0.08	0.01	0.34
98971	0.44	0.15	0.01	0.60

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Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
98972	0.69	0.21	0.02	0.92
98975	0.00	0.55	0.02	0.57
98976	0.00	1.47	0.01	1.48
98977	0.00	1.47	0.01	1.48
98980	0.62	0.80	0.04	1.46
98981	0.61	0.52	0.04	1.17
G0451	0.00	0.31	0.01	0.32
G2250	0.18	0.17	0.01	0.36
G2251	0.25	0.15	0.02	0.42

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