2021

Medicare Fee Schedule for Audiologists

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General Information

The American Speech-Language-Hearing Association (ASHA) developed this document to provide an analysis of the 2021 Medicare Physician Fee Schedule (MPFS), including comments on relevant policy changes, a list of Current Procedural Terminology (CPT® American Medical Association) codes used by audiologists with their national average payment amounts, and useful links to additional information.

Audiologists should always consult 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 audiology-specific payment and coding rules. For questions, contact reimbursement@asha.org.

Updates and Revisions

January 7, 2021

- Added information on Congressional action to mitigate the Medicare payment cuts. (p. 3)
- Updated the 2021 conversion factor. (p. 4)
- Updated advanced alternative payment model payment thresholds. (p. 7)
- Updated national payment rates and relative value units in Tables 1-3. (p. 8)

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Overview

Outpatient audiology 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 of the Medicare Access and CHIP Reauthorization Act of 2015. Additional payment adjustments—based on 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. 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, 2021, for audiologists providing services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include MIPS, new CPT codes for vestibular and auditory evoked potential testing, and national payment rates for audiology-related services.

ASHA's Medicare outpatient payment resources provide additional information regarding the MPFS, including background information, instructions for calculating Medicare payment, and audiology payment and coding rules. Note that a separate payment system applies to audiology services provided in hospital outpatient departments [PDF]. For questions, please contact reimbursement@asha.org.

Analysis of the 2021 Medicare Physician Fee Schedule (MPFS)

ASHA reviewed relevant sections of the 2021 MPFS final rule and offers the following analysis of key issues for audiologists.

Payment Rates

(updated 1/7/21)

In early December, CMS finalized significant rate reductions for audiologists, speech-language pathologists, and over 30 other Medicare provider groups due to changes in payment for primary care services and adjustments to the annual conversion factor (CF). However, following extensive advocacy by ASHA and other stakeholders, the Consolidated Appropriations Act, 2021 (H.R. 133) was signed into law on December 27, 2020, and included key provisions to mitigate the Medicare fee schedule cuts.

Rate Reductions to Audiology Services

Audiologists were set to see 6% decrease in payment for their services beginning in 2021. However, H.R. 133 addressed the cuts by providing a 3.75% increase to all payments made under the MPFS in 2021. In addition, other provisions of the legislation have softened the negative impact further. CMS released updated payment files on January 5, 2021. ASHA's analysis shows that, after all adjustments are applied, many audiology services will now see less than a 1% decrease in payment under the MPFS, and many others will even receive a slight increase over 2020 payments.

H.R. 133 also temporarily suspended Medicare sequestration that was set to expire on December 31, 2020. This suspension will increase payments to all providers by 2% through March 31, 2021. However, this additional increase is applied after claims are submitted and is not calculated in the fee schedule.

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Impact of Cuts on Actual Payment

It is important to note cumulative reimbursement changes experienced by individual audiologists or practices will vary, as actual payment depends on a number of factors, including locality-specific rates and the CPT codes billed. For example, CPT code 92570 (acoustic immittance testing) will now see a 0.23 % decrease to the national non-facility payment rate while CPT code 92540 (basic vestibular evaluation) will experience a 2.09% increase. As a result, audiologists wishing to determine the actual impact of the payment updates to their practice should calculate payments based on their specific billing patterns and locality.

See Table 1 (p. 8) for a listing of audiology-related procedures and corresponding national payment rates. The table also includes 2020 non-facility rates for comparison with 2021 rates to help audiologists estimate the impact of the updated payment rates. Visit ASHA's webpage on calculating Medicare fee schedule rates for information on how to access fees based on locality.

Background

The Medicare payment cuts are due to changes to office-based outpatient evaluation and management (E/M) procedure codes that provide payment increases for primary care services. By law, every year, CMS must ensure that rate changes for all procedure codes paid under the MPFS remain budget neutral. CMS implemented the 2021 reductions to offset the significant increase in value for the new E/M codes and to meet the Medicare program's budget neutrality mandate.

Although H.R. 133 significantly reduced the 2021 cuts, it didn't stop the E/M code changes, meaning the payment reductions will go into effect in 2022 to meet the budget neutrality mandate, unless Congress or CMS find a long-term policy solution. ASHA remains fully committed to fighting any cuts to Medicare reimbursement. While not perfect, H.R. 133 allows additional time for ASHA to continue working with stakeholders, Congress, and CMS to find a long-term policy solution. Learn more about ASHA's ongoing advocacy efforts and how audiologists can stay informed on this issue.

Conversion Factor (CF)

(updated 1/7/21)

CMS uses the CF to calculate MPFS payment rates. CMS inititally established a calendar year (CY) 2021 CF of $32.41 representing a 10.20% decrease from the $36.09 CF for 2020. This was due in large part to the increases to the E/M codes, necessitating a steep reduction in the CF to meet the budget neutrality mandate. Following Congressional intervention, the updated CY 2021 CF is now **$34.89**, representing a 7.65% increase from the original CF and a 3.33% decrease from 2020.

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 RVUs for any particular CPT code are multiplied by the CF to determine the corresponding fee. **See** Table 3 (p. 21) for a detailed chart of final 2021 RVUs.

ASHA, through its Health Care Economics Committee, has worked with other audiology and physician groups to present data to the American Medical Association (AMA) Relative Value Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC) to systematically transfer the audiologist's time and effort out of the practice expense and into 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 not yet complete, leaving some codes with only practice expense and malpractice components. ASHA is working collaboratively with the American Academy of Audiology (AAA) and other audiology and specialty societies to address these issues. See ASHA's website for more information on the CPT code development and valuation process [PDF].

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New and Updated CPT Codes

The MPFS final rule addresses values for several new CPT (Current Procedural Terminology ® American Medical Association) codes for vestibular evoked myogenic potentials (VEMP) and auditory evoked potentials (AEP) testing. ASHA worked with the American Academy of Audiology (AAA), American Academy of Neurology (AAN), and American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) to develop the codes and submit recommended values to CMS. ASHA's website and *The ASHA Leader* provide additional details regarding the 2021 CPT code changes.

Vestibular Evoked Myogenic Potential (VEMP) Testing

Beginning in 2021, audiologists can report VEMP testing with new CPT codes for **92517** for ocular (oVEMP) and **92518** for cervical (cVEMP) testing when performed alone, and bundled CPT code **92519** for oVEMP and cVEMP testing performed together on the same day. CMS accepted the recommended values from ASHA, AAA, AAN, and AAO-HNS, as outlined in Table 1 (p. 8) and Table 3 (p. 21).

Auditory Evoked Potential (AEP) Testing

Current AEP testing codes 92585 (comprehensive) and 92586 (limited) will be deleted in 2021 and replaced with four new, more descriptive CPT codes to reflect the spectrum of AEP testing. They describe automated screening of auditory potential with broadband stimuli (92650); testing for hearing status determination with broadband stimuli (92651); testing for threshold estimation at multiple frequencies (92652); and testing to evaluate neural conduction (92653).

CMS accepted the recommended values from ASHA, AAA, AAN, and AAO-HNS, as outlined below and in Table 1 (p. 8) and Table 3 (p. 21). Note that CMS does not cover screenings but published the total relative value units (RVUs) for CPT code 92650 for use by Medicaid programs and commercial insurers.

Payment Updates for CPT Codes Analogous to E/M Services

CMS increased payments for certain CPT codes related to evaluation services performed by a range of specialties, including speech-language pathology. CMS's goal is to maintain relativity in the fee schedule by ensuring that CPT codes that include assessment and management work similar to E/M codes reflect the positive changes in value that the E/M services will receive. ASHA urged CMS to implement similar increases for audiology codes, given the important role of audiologic and vestibular testing in assessing and managing balance, hearing, and communication disorders. However, CMS did not accept ASHA's recommendations because the audiology codes covered under the Medicare benefit represent diagnostic services, which CMS does not consider analogous to E/M services.

Communication Technology-Based Services (CTBS)

In its interim final rules related to the public health emergency (PHE), CMS temporarily allowed certain nonphysician qualified health care providers, including speech-language pathologists (SLPs), to report CTBS codes for virtual check-ins, e-visits, and remote assessment of recorded images or videos. The final rule permanently expands these services for SLPs and certain other nonphysician providers, beginning in 2021.

ASHA urged CMS to include audiologists as eligible providers of CTB services, both during and beyond the PHE. However, CMS did not expand Medicare coverage of CTBS codes for audiologists in 2021 nor during the PHE, specifically citing the limitations of the audiology diagnostic benefit in their rationale.

Coding and Payment for Personal Protective Equipment (PPE)

In early September 2020, the AMA released new CPT code 99072 and requested that CMS approve 99072 for reporting the cost of additional PPE, cleaning supplies, and clinician or clinical staff time needed to safely provide in-person services during the PHE. Unfortunately, Medicare will not cover 99072 because CMS considers the cost of PPE to be bundled into the payment for individual health care

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services and procedures. Instead, CMS will recognize the increased market-based pricing associated with certain PPE supply items, namely surgical masks, N95 masks, and face shields. CMS will automatically calculate the increased cost to purchase each item into the final payment for CPT codes, *but only if the CPT codes currently include these items in the practice expense component*. However, the supplies that are currently included in the practice expense component of each CPT code are based on pre-pandemic practice patterns. As such, CMS's action to increase the value of certain PPE supplies does not provide relief to audiologists because the CPT codes they commonly report do not include these items, such as surgical masks, in their practice expense component. ASHA continues to advocate with CMS and other payers to seek additional support for PPE supplies.

Medicare Telehealth Services

Although CMS addressed telehealth services in the final rule, there are no telehealth changes for audiologists in 2021. CMS lacks the statutory authority to maintain the telehealth flexibilities allowed during the PHE; therefore, audiologists will no longer receive Medicare reimbursement for telehealth services at the conclusion of the current PHE. ASHA will continue advocating with CMS and Congress to secure reimbursement for additional audiology telehealth services during the PHE and beyond.

ASHA is also working with Congress to pass legislation to include audiologists on the list of providers eligible for Medicare reimbursement for telehealth services by supporting H.R. 8755, the Expanded Telehealth Access Act.

The Quality Payment Program (QPP)

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established the Quality Payment Program (QPP). The QPP includes two tracks—the Merit-Based Incentive Payment System and Advanced Alternative Payment Models. Medicare modifies payment for outpatient services based on QPP participation. ASHA's website provides more information on the QPP.

Merit-Based Incentive Payment System (MIPS)

Audiologists first became eligible for MIPS in 2019 and will continue to participate in the program in 2021. If an audiologist meets the criteria for a MIPS eligible clinician (EC), they will need to report data associated with quality measures and improvement activities in 2021, which will be used to adjust their payments in 2023.

Since CMS has set exclusions and low-volume thresholds, a large majority of audiologists will be excluded from MIPS participation for 2021. 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 2023 Medicare payments for performance on the quality and improvement activities (IAs) performance categories in 2021.

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 audiologists—must report a minimum of six measures when/if six measures apply. In 2021, audiologists have nine potentially applicable measures.

- Measure 130: Documentation of Current Medications in the Medical Record

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- Measure 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Measure 154: Falls: Risk Assessment
- Measure 155: Falls: Plan of Care
- 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
- Measure 261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness
- Measure 318: Falls: Screening for Future Falls Risk

This will provide audiologists with the flexibility to select from nine options for reporting, as only a minimum of six measures need to be reported. ASHA's website provides additional details and ongoing updates regarding MIPS.

Advanced Alternative Payment Models (APMs)

(updated 1/7/21)

Advanced APMs are Medicare payment approaches that incentivize quality and value. Advanced APMs take a variety of forms, including accountable care organizations, direct contracting, patient-centered medical homes, bundled payments, and episodes of care. Audiologists **have been able to participate** in the Advanced APM option since 2017. Those who successfully participate in 2021 will be eligible to receive a 5% lump-sum incentive payment on their Part B services in 2023. An example of an Advanced APM is the Maryland Total Cost of Care Model.

CMS decides which clinicians will be considered participants in an Advanced APM 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 2021, an audiologist can qualify as a participant in an Advanced APM and receive the 5% incentive payment in 2023—if at least 50% of the group's Medicare payments or at least 35% of the group's Medicare patients receive services through the Advanced APM.

To allow more clinicians to qualify for the incentive payment, Medicaid, private insurance, and Medicare Advantage payments and patient counts are included in the All-Payer Combination option. To meet the payment or patient count thresholds under this option in 2021, a clinician must receive 50% of payments and provide services to 35% of all patients through the Advanced APM. The clinician has to also meet a 25% payment or 20% patient count threshold under the Medicare Option. This is to ensure that the clinician continues to provide covered services through the Advanced APM to Medicare patients in addition to other payer types.

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2021 Medicare Physician Fee Schedule for Audiology Services

Table 1. National Medicare Part B Rates for Audiology Services

(updated 1/7/21)

The following table contains full descriptors and national payment rates for services covered under the audiology diagnostic benefit. ASHA calculated rates by multiplying the total RVUs for each CPT code by the updated 2021 CF (**$34.89**). The table also includes 2020 non-facility rates for comparison with 2021 rates to help audiologists estimate the impact of the payment updates. Please see ASHA's Medicare outpatient payment website for other important information on Medicare CPT coding rules and Medicare fee calculations, including information on how to find rates by locality.

Medicare pays for audiology services at both facility and non-facility rates, depending on setting. Non-facility settings include physician offices, private practices, and outpatient clinics. Note that a separate payment system applies to audiology services provided in hospital outpatient departments. Please see ASHA's Medicare CPT Coding Rules for Audiology Services for additional Medicare Part B coding guidance.

See also: How to Read the MPFS and RVU Tables (p. 23)

Code	Mod	Descriptor	2020 National Fee	2021 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92517		Vestibular evoked myogenic potential testing, with interpretation and report; cervical (cVEMP)	N/A	**$87.23**	**$43.97**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021
92518		ocular (oVEMP)	N/A	**$81.30**	**$43.97**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021
92519		cervical (cVEMP) and ocular (oVEMP)	N/A	**$135.39**	**$65.95**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021 Report 92519 when performing cVEMP and oVEMP testing on the same day. Bill 92517 or 92518 if you don't perform both tests on the same day. Don't report 92519 in conjunction with 92517 or 92518.

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Code	Mod	Descriptor	2020 National Fee	2021 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92537		Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	$42.59	**$42.57**	**N/A**	
92537	TC	bithermal...	$10.11	**$10.82**	**N/A**	
92537	26	bithermal...	$32.48	**$31.75**	**$31.75**	
92538		monothermal (ie, one irrigation in each ear for a total of two irrigations)	$23.10	**$23.03**	**N/A**	
92538	TC	monothermal...	$6.50	**$6.98**	**N/A**	
92538	26	monothermal...	$16.60	**$16.05**	**$16.05**	
92540		Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	$109.71	**$112.01**	**N/A**	Report 92540 when completing all four components of the basic vestibular evaluation, as listed in the code descriptor. Bill 92541, 92542, 92544, or 92545 if you don't perform all four tests on the same day. Don't report 92540 in conjunction with 92541, 92542, 92544, or 92545.
92540	TC	Basic vestibular evaluation…	$28.15	**$32.80**	**N/A**	
92540	26	Basic vestibular evaluation…	$81.56	**$79.21**	**$79.21**	
92541		Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	$25.98	**$25.82**	**N/A**	
92541	TC	Spontaneous nystagmus test…	$4.33	**$4.54**	**N/A**	
92541	26	Spontaneous nystagmus test…	$21.65	**$21.28**	**$21.28**	
92542		Positional nystagmus test, minimum of 4 positions, with recording	$30.32	**$30.01**	**N/A**	
92542	TC	Positional nystagmus test…	$4.33	**$4.54**	**N/A**	
92542	26	Positional nystagmus test…	$25.98	**$25.47**	**$25.47**	

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Code	Mod	Descriptor	2020 National Fee	2021 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92544		Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	$18.04	**$18.49**	**N/A**	
92544	TC	Optokinetic nystagmus test…	$3.25	**$3.84**	**N/A**	
92544	26	Optokinetic nystagmus test…	$14.80	**$14.66**	**$14.66**	
92545		Oscillating tracking test, with recording	$16.96	**$17.10**	**N/A**	
92545	TC	Oscillating tracking test…	$3.25	**$3.49**	**N/A**	
92545	26	Oscillating tracking test…	$13.71	**$13.61**	**$13.61**	
92546		Sinusoidal vertical axis rotational testing	$113.68	**$121.43**	**N/A**	
92546	TC	Sinusoidal vertical axis rotational testing	$98.16	**$106.42**	**N/A**	
92546	26	Sinusoidal vertical axis rotational testing	$15.52	**$15.00**	**$15.00**	
92547		Use of vertical electrodes (List separately in addition to code for primary procedure)	$8.66	**$10.12**	**N/A**	Report this code in addition to the code(s) for the primary procedures for each vestibular test performed (92537-92546).
92548		Computerized dynamic posturography, sensory organization test (CDP-SOT)	$50.89	**$50.59**	**N/A**	
92548	TC	CDP-SOT	$15.16	**$15.70**	**N/A**	
92548	26	CDP-SOT	$35.73	**$34.89**	**$34.89**	
92549		with motor control test (MCT) and adaptation test (ADT)	$64.96	**$64.90**	**N/A**	This is a stand-alone code to report when performing all three CDP tests (SOT, MCT, and ADT). Don't bill in conjunction with 92548.
92549	TC	with MCT and ADT	$18.77	**$19.19**	**N/A**	
92549	26	with MCT and ADT	$46.19	**$45.71**	**$45.71**	

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Code	Mod	Descriptor	2020 National Fee	2021 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92550		Tympanometry and reflex threshold measurements	$22.74	**$22.68**	**N/A**	Report 92550 when performing both typanometry and reflex threshold measures on the same day. Bill 92567 or 92568 if you don't perform both tests on the same day. Don't report 92550 in conjunction with 92567 or 92568.
92552		Pure tone audiometry (threshold); air only	$32.12	**$32.80**	**N/A**	
92553		Pure tone audiometry (threshold); air and bone	$38.98	**$40.13**	**N/A**	
92555		Speech audiometry threshold;	$24.18	**$25.12**	**N/A**	
92556		with speech recognition	$38.62	**$39.78**	**N/A**	
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	$38.98	**$39.08**	**$33.15**	Don't report 92557 if you haven't completed all required components (pure tone air and bone conduction, speech reception thresholds, and speech recognition testing). Instead, bill for the individual components of testing using 92552, 92553, 92555, or 92556. Don't report 92557 in conjunction with 92552, 92553, 92555, or 92556.
92561		Bekesy audiometry; diagnostic	$39.70	**$40.13**	**N/A**	
92562		Loudness balance test, alternate binaural or monaural	$45.11	**$47.11**	**N/A**	
92563		Tone decay test	$31.04	**$31.75**	**N/A**	
92564		Short increment sensitivity index (SISI)	$24.18	**$24.08**	**N/A**	
92565		Stenger test, pure tone	$15.88	**$17.80**	**N/A**	
92567		Tympanometry (impedance testing)	$16.24	**$16.75**	**$10.82**	
92568		Acoustic reflex testing, threshold	$16.24	**$15.70**	**$15.35**	

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Code	Mod	Descriptor	2020 National Fee	2021 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92570		Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	$33.92	**$33.85**	**$30.36**	Don't 92570 if you haven't completed all three components of testing, as listed in the code descriptor. Instead, bill for the individual tests, 92567 or 92568. Don't report 92570 in conjunction with 92567 or 92568.
92571		Filtered speech test	$27.43	**$28.26**	**N/A**	
92572		Staggered spondaic word test	$35.37	**$36.29**	**N/A**	
92575		Sensorineural acuity level test	$66.40	**$69.44**	**N/A**	
92576		Synthetic sentence identification test	$36.81	**$38.38**	**N/A**	
92577		Stenger test, speech	$14.07	**$15.35**	**N/A**	
92579		Visual reinforcement audiometry (VRA)	$47.64	**$47.80**	**$38.73**	
92582		Conditioning play audiometry	$74.71	**$76.42**	**N/A**	
92583		Select picture audiometry	$49.08	**$51.29**	**N/A**	
92584		Electrocochleography	$75.07	**$121.43**	**N/A**	
92587		Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3–6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	$22.74	**$22.68**	**N/A**	See also: CPT Coding for Otoacoustic Emissions
92587	TC	Distortion product evoked otoacoustic emissions…limited	$3.61	**$4.19**	**N/A**	
92587	26	Distortion product evoked otoacoustic emissions…limited	$19.13	**$18.49**	**$18.49**	
92588		Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	$34.65	**$34.54**	**N/A**	See also: CPT Coding for Otoacoustic Emissions

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Code	Mod	Descriptor	2020 National Fee	2021 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92588	TC	Distortion product evoked otoacoustic emissions…comprehensive	$4.69	**$5.58**	**N/A**	
92588	26	Distortion product evoked otoacoustic emissions…comprehensive	$29.95	**$28.96**	**$28.96**	
92596		Ear protector attenuation measurements	$66.40	**$68.39**	**N/A**	
92601		Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	$170.70	**$170.28**	**$126.66**	
92602		subsequent reprogramming	$106.83	**$108.17**	**$71.53**	
92603		Diagnostic analysis of cochlear implant, age 7 years or older; with programming	$159.16	**$158.41**	**$123.17**	
92604		subsequent reprogramming	$95.28	**$95.96**	**$68.39**	
92620		Evaluation of central auditory function, with report; initial 60 minutes	$96.36	**$94.21**	**$81.65**	
92621		each additional 15 minutes (List separately in addition to code for primary procedure)	$23.10	**$23.03**	**$19.19**	This is an add-on code to report in conjunction with 92620 for each additional 15 minutes of evaluation.
92625		Assessment of tinnitus (includes pitch, loudness matching, and masking)	$72.18	**$70.83**	**$62.81**	
92626		Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); first hour	$92.39	**$91.77**	**$76.42**	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)	$22.01	**$21.63**	**$18.14**	This is an add-on code to report in conjunction with 92626 for each additional 15 minutes of evaluation.
92640		Diagnostic analysis with programming of auditory brainstem implant, per hour	$116.93	**$115.50**	**$96.30**	

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Code	Mod	Descriptor	2020 National Fee	2021 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92651		Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	N/A	**$91.42**	**N/A**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021 92651 describes nonautomated follow-up electrophysiologic testing to rule out significant hearing loss, including auditory neuropathy/auditory dyssynchrony, or to verify the need for additional threshold testing. Testing includes obtaining responses to broadband-evoked auditory brainstem responses (ABRs) using click stimuli at moderate-to-high and low stimulus levels. Don't report 92651 in conjunction with 92652 or 92653.
92652		for threshold estimation at multiple frequencies, with interpretation and report	N/A	**$119.68**	**N/A**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021 92652 describes extensive electrophysiologic estimation of behavioral hearing thresholds using broadband and/or frequency-specific stimuli at multiple levels and frequencies. 92652 can also include testing with high level stimuli and rarefaction/condensation runs to confirm auditory neuropathy/auditory dyssynchrony. 92652 reflects comprehensive AEP testing for the purpose of quantifying type and degree of hearing loss. Don't report 92652 in conjunction with 92651 or 92653.

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Code	Mod	Descriptor	2020 National Fee	2021 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92653		neurodiagnostic, with interpretation and report	N/A	**$87.58**	**N/A**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021 92653 describes testing to evaluate neural integrity only, without defining threshold. Report this code when the purpose of testing is to identify brainstem or auditory nerve function. 92653 is a less extensive test than 92652 and the basic elements of 92653 are already included in 92651 or 92652 when they are performed to identify and quantify hearing impairment. Don't report 92653 in conjunction with 92651 or 92652.
92700		Unlisted otorhinolaryngological service or procedure	MAC priced	**MAC priced**	**MAC priced**	See also: New Procedures...But No Codes

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Table 2. National Medicare Part B Rates for Treatment, Electrophysiology, or Non-Benefit Services

(updated 1/7/21)

Audiologists may not directly bill Medicare for the procedures listed in this table because CMS reimburses audiologists only for hearing and balance diagnostic services. Although they are within the scope of practice of an ASHA-certified audiologist, Medicare does not recognize screenings, treatment, hearing aid, and electrophysiological services outside the hearing and balance systems when performed by an audiologist. Services in this table that are included as a Medicare benefit may be billed to Medicare when performed under the supervision of a physician and billed under the physician's National Provider Identifier (NPI) number ("incident to"). Services listed in Table 1 (p.8) that are part of the audiology benefit must be billed under the audiologists' NPI and may *not* be billed "incident to" a physician (i.e., under the physician's NPI).

Code	Mod	Descriptor	2021 National Fee		Notes
			Non-Facility	*Facility*	
69209		Removal impacted cerumen using irrigation/lavage, unilateral	**$15.35**	**N/A**	Not covered under the audiology benefit.
69210		Removal impacted cerumen requiring instrumentation, unilateral (for bilateral procedure, report 69210)	**$48.50**	**$33.85**	Not covered under the audiology benefit.
92516		Facial nerve function studies (eg, electroneuronography)	**$70.83**	**$23.38**	Covered under physician supervision.
92531		Spontaneous nystagmus, including gaze	**$0.00**	**$0.00**	Medicare doesn't cover vestibular tests *without* recording. See **92537-92548** in Table 1 for vestibular tests with recording.
92532		Positional nystagmus test	**$0.00**	**$0.00**	
92533		Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests)	**$0.00**	**$0.00**	
92534		Optokinetic nystagmus test	**$0.00**	**$0.00**	
92551		Screening test, pure tone, air only	**$11.86**	**N/A**	Medicare doesn't cover screenings, but rates are published as reference, when available.
92558		Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	**$9.77**	**$8.72**	Medicare doesn't cover screenings, but rates are published as reference, when available.
92559		Audiometric testing of groups	**$0.00**	**$0.00**	This service isn't paid under the MPFS.
92560		Bekesy audiometry; screening	**$0.00**	**$0.00**	Medicare doesn't cover screenings.
92590		Hearing aid examination and selection; monaural	**$0.00**	**$0.00**	

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Code	Mod	Descriptor	2021 National Fee		Notes
			Non-Facility	*Facility*	
92591		binaural	**$0.00**	**$0.00**	Medicare doesn't cover services related to hearing aids.
92592		Hearing aid check; monaural	**$0.00**	**$0.00**	
92593		binaural	**$0.00**	**$0.00**	
92594		Electroacoustic evaluation for hearing aid; monaural	**$0.00**	**$0.00**	
92595		binaural	**$0.00**	**$0.00**	
92630		Auditory rehabilitation; prelingual hearing loss	**$0.00**	**$0.00**	Not recognized by Medicare.
92633		postlingual hearing loss	**$0.00**	**$0.00**	Not recognized by Medicare.
92650		Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	**$28.96**	**N/A**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021 Medicare doesn't cover screenings, but rates are published as reference, when available.
95907		Nerve conduction studies; 1–2 studies	**$97.00**	**N/A**	Covered under physician supervision.
95907	TC	1–2 studies	**$42.92**	**N/A**	
95907	26	1–2 studies	**$54.08**	**$54.08**	
95908		Nerve conduction studies; 3–4 studies	**$122.47**	**N/A**	Covered under physician supervision.
95908	TC	3–4 studies	**$54.78**	**N/A**	
95908	26	3–4 studies	**$67.69**	**$67.69**	
95909		Nerve conduction studies; 5–6 studies	**$146.20**	**N/A**	Covered under physician supervision.
95909	TC	5–6 studies	**$65.60**	**N/A**	
95909	26	5–6 studies	**$80.60**	**$80.60**	
95910		Nerve conduction studies; 7–8 studies	**$192.26**	**N/A**	Covered under physician supervision.
95910	TC	7–8 studies	**$83.74**	**N/A**	
95910	26	7–8 studies	**$108.52**	**$108.52**	
95911		Nerve conduction studies; 9–10 studies	**$230.64**	**N/A**	Covered under physician supervision.
95911	TC	9–10 studies	**$95.96**	**N/A**	
95911	26	9–10 studies	**$134.69**	**$134.69**	
95912		Nerve conduction studies; 11–12 studies	**$266.93**	**N/A**	

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Code	Mod	Descriptor	2021 National Fee		Notes
			Non-Facility	*Facility*	
95912	TC	11–12 studies	**$105.73**	**N/A**	Covered under physician supervision.
95912	26	11–12 studies	**$161.21**	**$161.21**	
95913		Nerve conduction studies; 13 or more studies	**$309.85**	**N/A**	Covered under physician supervision.
95913	TC	13 or more studies	**$118.99**	**N/A**	
95913	26	13 or more studies	**$190.87**	**$190.87**	
95925		Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	**$161.21**	**N/A**	Covered under physician supervision.
95925	TC	in upper limbs	**$132.24**	**N/A**	
95925	26	in upper limbs	**$28.96**	**$28.96**	
95926		in lower limbs	**$148.64**	**N/A**	Covered under physician supervision.
95926	TC	in lower limbs	**$120.73**	**N/A**	
95926	26	in lower limbs	**$27.91**	**$27.91**	
95938*		in upper and lower limbs	**$369.17**	**N/A**	*Out of numerical order. Covered under physician supervision.
95938	TC	in upper and lower limbs	**$322.76**	**N/A**	
95938	26	in upper and lower limbs	**$46.41**	**$46.41**	
95927		in the trunk or head	**$145.85**	**N/A**	Covered under physician supervision.
95927	TC	in the trunk or head	**$118.64**	**N/A**	
95927	26	in the trunk or head	**$27.91**	**$27.22**	
95930		Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	**$68.74**	**N/A**	Covered under physician supervision.
95930	TC	checkerboard or flash	**$49.90**	**N/A**	
95930	26	checkerboard or flash	**$18.84**	**$18.84**	
95937		Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	**$107.12**	**N/A**	Covered under physician supervision.
95937	TC	Neuromuscular junction testing…	**$71.88**	**N/A**	
95937	26	Neuromuscular junction testing…	**$35.24**	**$35.24**	

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Code	Mod	Descriptor	2021 National Fee		Notes
			Non-Facility	*Facility*	
95940		Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	**N/A**	**$33.15**	Covered under physician supervision.
95941		Continuous neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	**$0.00**	**$0.00**	Not recognized by Medicare. **See G0453 below**.
95992		Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day	**$44.66**	**$37.34**	Not covered under the audiology benefit.
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	**$11.86**	**$11.51**	**Updated in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021 and Use of CTBS Codes During COVID-19 Not covered under the audiology benefit.
98971		11-20 minutes	**$20.94**	**$20.59**	**Updated in 2021.** See note for 98970.
98972		21 or more minutes	**$32.80**	**$32.80**	**Updated in 2021.** See note for 98970.
G0453		Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (List in addition to primary procedure)	**N/A**	**$33.15**	Covered under physician supervision.

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Code	Mod	Descriptor	2021 National Fee		Notes
			Non-Facility	*Facility*	
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	**$12.21**	**$9.42**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021 and Use of CTBS Codes During COVID-19 Not covered under the audiology benefit.
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	**$14.66**	**$13.26**	**New in 2021.** See also: Audiology CPT and HCPCS Code Changes for 2021 and Use of CTBS Codes During COVID-19 Not covered under the audiology benefit.

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Table 3. Detailed Relative Value Units (RVUs) for Audiology Services

(updated 1/7/21)

This table contains only RVUs for codes covered under the audiology benefit, as listed in Table 1 (p. 8). For geographically-adjusted RVUs, go to Addendum E in the CMS CY 2021 PFS Final Rule Addenda [ZIP] files. **See also:** How to Read the MPFS and RVU Tables (p. 23)

Code	Mod	Professional Work	Malpractice	Non-Facility Practice Expense	Non-Facility Total	Facility Practice Expense	Facility Total
92517		0.80	0.04	1.66	2.50	0.42	1.26
92518		0.80	0.04	1.49	2.33	0.42	1.26
92519		1.20	0.05	2.63	3.88	0.64	1.89
92537		0.60	0.02	0.60	1.22	N/A	N/A
92537	TC	0.00	0.01	0.30	0.31	N/A	N/A
92537	26	0.60	0.01	0.30	0.91	0.30	0.91
92538		0.30	0.02	0.34	0.66	N/A	N/A
92538	TC	0.00	0.01	0.19	0.20	N/A	N/A
92538	26	0.30	0.01	0.15	0.46	0.15	0.46
92540		1.50	0.05	1.66	3.21	N/A	N/A
92540	TC	0.00	0.01	0.93	0.94	N/A	N/A
92540	26	1.50	0.04	0.73	2.27	0.73	2.27
92541		0.40	0.02	0.32	0.74	N/A	N/A
92541	TC	0.00	0.01	0.12	0.13	N/A	N/A
92541	26	0.40	0.01	0.20	0.61	0.20	0.61
92542		0.48	0.02	0.36	0.86	N/A	N/A
92542	TC	0.00	0.01	0.12	0.13	N/A	N/A
92542	26	0.48	0.01	0.24	0.73	0.24	0.73
92544		0.27	0.02	0.24	0.53	N/A	N/A
92544	TC	0.00	0.01	0.10	0.11	N/A	N/A
92544	26	0.27	0.01	0.14	0.42	0.14	0.42
92545		0.25	0.02	0.22	0.49	N/A	N/A
92545	TC	0.00	0.01	0.09	0.10	N/A	N/A
92545	26	0.25	0.01	0.13	0.39	0.13	0.39
92546		0.29	0.03	3.16	3.48	N/A	N/A
92546	TC	0.00	0.02	3.03	3.05	N/A	N/A
92546	26	0.29	0.01	0.13	0.43	0.13	0.43
92547		0.00	0.00	0.29	0.29	N/A	N/A
92548		0.67	0.03	0.75	1.45	N/A	N/A
92548	TC	0.00	0.01	0.44	0.45	N/A	N/A
92548	26	0.67	0.02	0.31	1.00	0.31	1.00
92549		0.87	0.05	0.94	1.86	N/A	N/A
92549	TC	0.00	0.01	0.54	0.55	N/A	N/A
92549	26	0.87	0.04	0.40	1.31	0.40	1.31
92550		0.35	0.02	0.28	0.65	N/A	N/A

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Code	Mod	Professional Work	Malpractice	Non-Facility Practice Expense	Non-Facility Total	Facility Practice Expense	Facility Total
92552		0.00	0.01	0.93	0.98	N/A	N/A
92553		0.00	0.01	1.14	1.19	N/A	N/A
92555		0.00	0.01	0.71	0.74	N/A	N/A
92556		0.00	0.01	1.13	1.17	N/A	N/A
92557		0.60	0.04	0.48	1.11	0.31	0.95
92561		0.00	0.02	1.13	1.21	N/A	N/A
92562		0.00	0.01	1.34	1.38	N/A	N/A
92563		0.00	0.01	0.90	0.95	N/A	N/A
92564		0.00	0.01	0.68	0.73	N/A	N/A
92565		0.00	0.01	0.50	0.52	N/A	N/A
92567		0.20	0.01	0.27	0.49	0.10	0.31
92568		0.29	0.02	0.14	0.46	0.13	0.44
92570		0.55	0.04	0.38	0.96	0.28	0.87
92571		0.00	0.01	0.80	0.82	N/A	N/A
92572		0.00	0.01	1.03	1.11	N/A	N/A
92575		0.00	0.02	1.97	2.05	N/A	N/A
92576		0.00	0.01	1.09	1.11	N/A	N/A
92577		0.00	0.01	0.43	0.47	N/A	N/A
92579		0.70	0.04	0.63	1.36	0.37	1.11
92582		0.00	0.02	2.17	2.24	N/A	N/A
92583		0.00	0.01	1.46	1.51	N/A	N/A
92584		1.00	0.05	2.43	3.56	N/A	N/A
92587		0.35	0.02	0.28	0.65	N/A	N/A
92587	TC	0.00	0.01	0.11	0.12	N/A	N/A
92587	26	0.35	0.01	0.17	0.53	0.17	0.53
92588		0.55	0.02	0.42	1.00	N/A	N/A
92588	TC	0.00	0.01	0.15	0.16	N/A	N/A
92588	26	0.55	0.01	0.27	0.84	0.27	0.83
92596		0.00	0.01	1.95	1.99	N/A	N/A
92601		2.30	0.09	2.49	4.86	1.24	3.63
92602		1.30	0.05	1.75	3.10	0.70	2.05
92603		2.25	0.09	2.20	4.54	1.19	3.53
92604		1.25	0.05	1.45	2.76	0.66	1.96
92620		1.50	0.05	1.15	2.73	0.79	2.34
92621		0.35	0.01	0.30	0.65	0.19	0.55
92625		1.15	0.05	0.83	2.03	0.60	1.80
92626		1.40	0.07	1.16	2.63	0.74	2.19
92627		0.33	0.01	0.28	0.62	0.18	0.52
92640		1.76	0.05	1.50	3.32	0.95	2.76
92651		1.00	0.05	1.57	2.64	N/A	N/A
92652		1.50	0.09	1.84	3.49	N/A	N/A
92653		1.05	0.05	1.41	2.57	N/A	N/A

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How to Read the MPFS and RVU Tables

Modifiers:

26: "Professional component," the portion of a diagnostic test that involves a clinician's work and allocation of the practice expense.

TC: "Technical component," for diagnostic tests, the portion of a procedure that does not include a clinician's participation. *The TC value is the difference between the global value and the professional component (26).*

No Modifier: "Global value," includes both professional and technical components. Typically, services provided by an audiologist will be paid at the global value when both testing and interpretation and report are completed by the audiologist.

"N/A" in Fee Columns:

Non-Facility: No rate established because service is typically performed in the hospital. If the contractor determines the service can be performed in the non-facility setting, it will be paid at the facility rate.

Facility: No rate established because service is not typically paid under the MPFS when provided in a facility setting. These services, including "incident to" and the TC portion of diagnostic tests, are generally paid under the hospital OPPS or bundled into the hospital inpatient prospective payment system. In some cases, these services may be paid in a facility setting at the MPFS rate, but there would be no payment made to the practitioner under the MPFS in these situations.

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