2021

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 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 speech-language pathologists (SLPs) with their national average payment amounts, and useful links to additional information.

SLPs 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 speech-language pathology 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. 8)
- Updated national payment rates and relative value units in Tables 1-3. (p. 9)

December 11, 2020

- Updated "KX" modifier threshold amount for targeted manual medical review. (p. 6)
- Provided additional detail regarding telehealth services during and after the public health emergency. (p. 6)

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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 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 speech-language pathologists (SLPs) who provide services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include MIPS, communication technology-based services, telehealth, and national payment rates for speech-language pathology-related services.

ASHA's Medicare outpatient payment resources provide additional information regarding the MPFS, including background information, instructions for calculating Medicare payment, and speech-language pathology payment and coding rules. 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 SLPs.

Payment Rates

(updated 1/7/21)

In early December, CMS finalized significant rate reductions for audiologists, SLPs, 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 Speech-Language Pathology Services

SLPs were set to see a 9% decrease in payment for Medicare Part B services provided in all settings 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, most speech-language pathology services will now see a 3-4% decrease in payment under the MPFS.

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.

Impact of Cuts on Actual Payment

It is important to note that the cumulative impact of the cuts experienced by individual SLPs 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 92507 (speech, language, communication treatment) will see a

3.75% decrease to the national payment rate while CPT code 92611 (videofluoroscopic swallow study) will experience only a 0.73% decrease. As a result, SLPs wishing to determine the actual impact of the payment cuts 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 2020 non-facility rates for comparison with 2021 rates to help SLPs 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 SLPs 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.

Payment Increases for Certain Speech-Language Pathology Evaluation Codes

CMS increased the values for four procedure codes related to the evaluation of speech, language, fluency, and voice (92521-92524) by approximately 28%. However, due to the reduced 2021 CF, the actual payment for these CPT codes will increase by 18-21%. 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 received. ASHA supported this effort and provided CMS with recommendations for other evaluation codes that should also receive increased payments, such as clinical swallowing and speech-generating device evaluations. However, CMS chose not to expand the list of speech-language pathology services receiving an increase in 2021. Although these increases are necessary, they do little to lessen the overall negative impact of the payment cuts on SLPs, as evaluations make up only a small portion of total payment for therapy services for most clinicians.

See Table 1 (p. 9) for 2021 payment rates for CPT codes 92521-92524.

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 3 (p. 17) for a detailed chart of final 2021 RVUs.

Multiple Procedure Payment Reductions (MPPR)

The MPPR policy for speech-language pathology and other services will continue in 2021. 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.

New and Updated CPT Codes

The MPFS final rule addresses values for new and updated procedure codes related to communication technology-based services (CTBS), which are being permanently added to the list of codes SLPs may bill to Medicare. There are no other changes to CPT codes directly related to speech-language pathology services for 2021. ASHA's website and *The ASHA Leader* provide more information on 2021 CPT code updates.

Communication Technology-Based Services (CTBS)

Due to the COVID-19 pandemic, CMS has temporarily allowed SLPs to report the CTBS codes for e-visits, virtual check-ins, and remote assessment of recorded images or videos, for the duration of the federal public health emergency (PHE). The final rule permanently expands these services to SLPs, and certain other nonphysician providers, beginning in 2021.

The CPT and Healthcare Common Procedure Coding System (HCPCS) codes for CTB services describe brief communications conducted over different types of technology to help avoid unnecessary office visits. These services include e-visits (98970–98972 and G2061–G2063), virtual check-ins (G2012), and remote assessment of recorded images or videos (G2010).

SLPs will see some changes in the CTBS codes in 2021, though the key components and coding requirements for these services will not change. The codes are updated only to better describe virtual assessments conducted by nonphysician health care providers.

- G2061–G2063 are deleted, so clinicians will report e-visits with CPT codes **98970**–**98972**, eliminating current confusion caused by CPT and G-codes available to report similar services.
- Remote assessment of recorded images or videos for nonphysician health care providers are reported with the new **G-code G2250** and virtual check-ins with **G2251.** G2010 and G2012, the codes currently used by SLPs to report these services, will remain, but not for use by SLPs or other nonphysician providers.

CMS designated G2250, G2251, and 98970–98972 as "sometimes therapy" codes. As a result, SLPs should include the "GN" modifier on claims for CTBS codes during and beyond the PHE.

It is important to note that the coding and documentation guidelines associated with CTBS codes have been loosened for the duration of the PHE. For example, during the PHE, CTBS codes may be reported for both new and established patients but, under normal circumstances, they may only be reported for established patients. In addition, CMS isn't permanently expanding use of the telephone assessment

codes (98966-98968), though they are available during the PHE. Once the PHE is over, SLPs may continue to report G2250, G2251, and 98970-98972 under the MPFS but must be aware of the more restrictive coding and documentation requirements for each code.

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

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 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 SLPs 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.

Targeted Manual Medical Review

(updated 12/11/20)

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 2021 is $2,110 for physical therapy and speech-language pathology services, combined.

ASHA's website provides more information regarding the permanent repeal of the cap and the current targeted medical review process.

Medicare Telehealth Services

(updated 12/11/20)

Medicare reimbursement for telehealth services is complicated by the limitations of federal law and the temporary flexibilities developed to help clinicians and patients navigate the federally-declared PHE. SLPs should be aware of how telehealth coverage will change once the PHE is over.

The federally-declared PHE is renewable every 90 days. ASHA will continue providing updates on the status of the PHE and any future extensions on the advocacy webpage and through ASHA Headlines.

During the PHE

Medicare has authorized SLPs to provide a narrow subset of telehealth services during the federally-declared PHE. SLPs should be aware of two key considerations during this time.

- You can not charge Medicare beneficiaries for these specific services and must bill Medicare directly.

- If a service is not on the temporarily authorized telehealth services list, you may enter into a private pay arrangement with the Medicare beneficiary for that specific service (dysphagia evaluation or treatment, for example).

ASHA will continue advocating for Medicare reimbursement for dysphagia, cognitive, and speech-generating device services during the PHE.

After the PHE Ends

Once the federally-declared PHE ends, Medicare will no longer reimburse SLPs directly for any telehealth services. SLPs will have two options for reimbursement for Medicare telehealth services.

- You can enter into private pay arrangements with Medicare beneficiaries.
- You can provide select telehealth services "incident to" a physician, meaning these services would be provided under the direct supervision of a physician and billed under the physician's NPI. This option is only available through the remainder of 2021.
    - Direct supervision means the physician is in the office suite (but not necessarily in the same room) or available through real time audio-visual communication technology.
    - The services SLPs may provide incident to a physician are **92507** (speech, language, communication treatment), **92521** (fluency evaluation), **92522** (speech sound evaluation), **92523** (speech and language evaluation), and **92524** (voice evaluation).

ASHA will continue advocating with Congress for a change in federal law that would permanently extend Medicare reimbursement for telehealth services provided by SLPs.

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. ASHA's website provides more information on the QPP.

Merit-Based Incentive Payment System (MIPS)

SLPs first became eligible for MIPS for 2019 and will continue to participate in the program in 2021. 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 2021 that will be used to adjust their payments in 2023.

Since CMS has set exclusions and low-volume thresholds, a large majority of SLPs 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 SLPs—must report a minimum of six measures when/if six measures apply. In 2021, SLPs have five applicable measures, as outlined below.

- 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

This means that SLPs must report all five measures whenever applicable; since there are only five possible measures SLPs will *not* be penalized for reporting on fewer than six measures. 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. SLPs **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 SLP 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.

2021 Medicare Physician Fee Schedule for Speech-Language Pathology Services

Table 1. National Medicare Part B Rates for Speech-Language Pathology Services

(updated 1/7/21)

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 updated 2021 CF (**$34.89**). The table also includes 2020 non-facility rates for comparison with 2021 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	2020 National Fee	2021 National Fee	Notes
31579	Laryngoscopy, flexible or rigid telescopic; with stroboscopy	$197.05	**$201.68**	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	$81.20	**$78.16**	SLPs may also use 92507 to report auditory (aural) rehabilitation.
92508	group, 2 or more individuals	$24.54	**$24.08**	See also: Medicare Guidelines for Group Therapy and Modes of Service Delivery for Speech-Language Pathology
92511	Nasopharyngoscopy with endoscope (separate procedure)	$114.76	**$120.38**	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)	$60.99	**$61.41**	
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	$82.28	**$82.35**	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	$115.85	**$136.78**	

Code	Descriptor	2020 National Fee	2021 National Fee	Notes
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	$94.55	**$114.45**	Don't bill 92522 in conjunction with 92523.
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	$198.49	**$235.18**	Don't bill 92523 in conjunction with 92522.
92524	Behavioral and qualitative analysis of voice and resonance	$92.39	**$112.01**	This procedure doesn't include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding	$89.50	**$86.53**	See also: Answers to Your Feeding/Swallowing Coding Questions
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	$75.07	**$72.58**	
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	$132.09	**$127.71**	See also: Billing for AAC and Device Documentation
92608	each additional 30 minutes (List separately in addition to code for primary procedure)	$53.05	**$51.29**	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	$111.16	**$106.77**	See also: Billing for AAC and Device Documentation
92610	Evaluation of oral and pharyngeal swallowing function	$89.14	**$86.53**	See also: Answers to Your Feeding/Swallowing Coding Questions
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	$94.55	**$93.86**	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;	$203.55	**$201.33**	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

Code	Descriptor	2020 National Fee	2021 National Fee	Notes
92613	interpretation and report only	$38.98	**$37.34**	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.
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	$152.30	**$150.04**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act.
92615	interpretation and report only	$34.29	**$33.15**	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;	$221.59	**$220.87**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act.
92617	interpretation and report only	$42.59	**$41.52**	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	$92.39	**$91.42**	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**	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	$105.74	**$101.54**	

Code	Descriptor	2020 National Fee	2021 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	**$131.55**	
96113	each additional 30 minutes (List separately in addition to code for primary procedure)	$62.80	**$58.62**	
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	**$107.12**	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	$24.54	**$23.38**	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)	$23.46	**$22.68**	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	**$61.06**	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

Code	Descriptor	2020 National Fee	2021 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	$35.01	**$33.85**	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	N/A	**$11.86**	**Updated in 2021.** See also: Speech-Language Pathology CPT and HCPCS Code Changes for 2021 and Use of CTBS Codes During COVID-19
98971	11-20 minutes	N/A	**$20.94**	**Updated in 2021.** See note for 98970.
98972	21 or more minutes	N/A	**$32.80**	**Updated in 2021.** See note for 98970.
G0451	Developmental testing, with interpretation and report, per standardized instrument form	$10.11	**$10.12**	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	N/A	**$12.21**	**New in 2021.** See also: Speech-Language Pathology CPT and HCPCS Code Changes for 2021 and Use of CTBS Codes During COVID-19

Code	Descriptor	2020 National Fee	2021 National Fee	Notes
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	N/A	**$14.66**	**New in 2021.** See also: Speech-Language Pathology CPT and HCPCS Code Changes for 2021 and 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

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

(updated 1/7/21)

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	2021 National Fee	Notes
31575	Laryngoscopy, flexible; diagnostic	**$131.20**	This procedure is for medical diagnosis by a physician.
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	**$112.01**	This is a radiology code.
74230	Swallowing function, with cineradiography/videoradiography	**$136.43**	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	**$119.33**	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	**$95.61**	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)	**$33.50**	*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	**$85.14**	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.

Code	Descriptor	2021 National Fee	Notes
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.
96110	Developmental screening, with interpretation and report, per standardized instrument form	**$10.12**	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	**$30.36**	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	**$35.24**	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)	**$18.14**	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	**$39.43**	This is a PMR code. CMS won't pay for this code when reported by an SLP. See also: Use of Physical Medicine Codes

Table 3. Detailed Relative Value Units (RVUs) for Speech-Language Pathology Services

(updated 1/7/21)

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 2021 PFS Final Rule Addenda [ZIP] files.

Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
31579	1.88	3.65	0.25	5.78
92507	1.30	0.89	0.05	2.24
92508	0.33	0.35	0.01	0.69
92511	0.61	2.80	0.04	3.45
92512	0.55	1.17	0.04	1.76
92520	0.75	1.57	0.04	2.36
92521	2.24	1.59	0.09	3.92
92522	1.92	1.26	0.10	3.28
92523	3.84	2.75	0.15	6.74
92524	1.92	1.20	0.09	3.21
92526	1.34	1.09	0.05	2.48
92597	1.26	0.77	0.05	2.08
92607	1.85	1.75	0.06	3.66
92608	0.70	0.73	0.04	1.47
92609	1.50	1.51	0.05	3.06
92610	1.30	1.13	0.05	2.48
92611	1.34	1.26	0.09	2.69
92612	1.27	4.44	0.06	5.77
92613	0.71	0.32	0.04	1.07
92614	1.27	2.97	0.06	4.30
92615	0.63	0.28	0.04	0.95
92616	1.88	4.34	0.11	6.33
92617	0.79	0.35	0.05	1.19
92626	1.40	1.17	0.05	2.62
92627	0.33	0.28	0.01	0.62
96105	1.75	1.06	0.10	2.91
96112	2.56	1.07	0.14	3.77
92613	1.16	0.47	0.05	1.68
96125	1.70	1.28	0.09	3.07
97129	0.50	0.15	0.02	0.67
97130	0.48	0.14	0.02	0.65
97533	0.48	1.25	0.02	1.75
97535	0.45	0.50	0.02	0.97
98970	0.25	0.08	0.01	0.34

Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
98971	0.44	0.14	0.02	0.60
98972	0.69	0.21	0.04	0.94
G0451	0.00	0.28	0.01	0.29
G2250	0.18	0.16	0.01	0.35
G2251	0.25	0.15	0.02	0.42

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