2024

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 2024 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.

Updates and Revisions

April 2024: Updated Medicare fee schedule rates to reflect an increased conversion factor (CF) effective for dates of service on or after March 9, 2024. The increased CF was included in the Consolidated Appropriations Act of 2024, which reduced the magnitude of the Medicare Part B fee schedule reductions. (page 8)

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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, 2024, 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 2024 Medicare Physician Fee Schedule (MPFS)

ASHA reviewed relevant sections of the 2024 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 will continue in 2024. These cuts would have also gone into effect in 2021, 2022, and 2023 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—including in 2024—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 2024 and to seek long-term solutions to fix the Medicare outpatient payment system. The Consolidated Appropriations Act of 2023 included a 1.25% positive adjustment for 2024, and after considerable advocacy, the Consolidated Appropriations Act of 2024 further reduced the cuts for the last three quarters of 2024.

In addition, payment cuts are set to return in 2025. ASHA strongly encourages SLPs to contact their members of Congress and ask them to 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) 2024 CF of **$32.74**, representing a 3.4% decrease from the $33.89 CF for 2023 for services provided between January 1 and March 8, 2024. Following extensive advocacy, the Consolidated Appropriations Act of 2024 increased Medicare spending by approximately 1.7% which increased the CF to **$33.29** for dates of service on or after March 9, 2024. The decrease in the CF is due in large part to the expiration of the temporary 2.5% positive adjustment that Congress implemented to mitigate significant payment cuts in 2023 and Medicare's requirement to maintain a budget neutral program.

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 3% change in payments. The analysis also shows that most individual SLPs will experience between a negative 2% to a negative 5% shift in reimbursement in 2024 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). Before Congress took action earlier this year, this could have resulted in a total cut of over 10-12% to overall Medicare payments when added to the MPFS payment cuts. Congress has consistently acted by passing legislation that significantly reduced some of the cuts over the past few years. ASHA continues to advocate for legislation to address these annual reductions and ensure SLPs are aware of the potential impact on their Medicare payments.

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 3% 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. 10) for a listing of speech-language pathology procedures and corresponding national payment rates. The table also includes 2023 non-facility rates for comparison with 2024 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. 19)** for a detailed chart of final 2024 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 2024. 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. It is important to note that CPT codes for services typically billed by SLPs are less susceptible to MPPR reductions because most are untimed service-based codes with higher values than timed codes typically billed by

occupational and physical therapists. Visit ASHA's website for more information on MPPR, including billing scenarios and a list of the speech-language pathology codes subject to MPPR.

CPT Code Updates

The final rule implements the following CPT code changes in the 2024 MPFS. ASHA's website provides more information on 2024 coding updates.

Caregiver Training Without the Patient Present

Beginning in 2024, SLPs can report caregiver training services (CTS) without the patient present, when provided under an established, individualized, and patient-centered plan of care. This marks the first time CMS will allow therapists, including SLPs, to bill and receive MPFS payment for services without the patient present. CMS acknowledges the importance and efficacy of reasonable and necessary caregiver training to influence successful health outcomes for patients.

97550 Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes

97551 each additional 15 minutes (List separately in addition to code for primary service)

97552 Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers

SLPs billing for CTS without the patient present should append the "GN" modifier to indicate that these services are being provided under a speech-language pathology of care. However, because CMS has identified these codes as "sometimes therapy" codes, they will not be subject to the multiple procedures payment reduction (MPPR) policy. Only codes labeled as "always therapy" are subject to MPPR.

Correct billing for caregiver training is based on the individual patient whose caregiver(s) require training to help with the treatment plan and facilitate functional performance. Billing is **not** based on the number of caregivers in the training session.

- Training for the caregivers of one patient is billed with two timed codes for the initial 30 minutes (97550) and each additional 15 minutes (97551). Clinicians will bill caregiver training for an individual patient once per session, regardless of the number of caregivers involved in the training.
- Group training for caregivers of more than one patient is billed with one untimed code (97552) per patient represented in the group. Clinicians will bill group caregiver training once per patient, not once per caregiver.

However, CMS has provided conflicting information in the final rule. Although CMS acknowledged that billing is based on the patient, the agency also stated in its coding guidance that billing should be based on the number of caregivers, rather than the number of patients represented. This interpretation is not consistent with the intent of the codes and will cause confusion among payers and providers as they implement the new codes in 2024.

ASHA is working with related stakeholders to request that CMS issue updated guidance with accurate coding and billing instructions and will provide updates on ASHA's website. In the meantime, ASHA recommends clinicians bill based on the patient, as set forth in the CPT codebook and outlined in ASHA's coding resource.

Caregiver Definition

For the purposes of the CTS policy, CMS will use two definitions that the agency believes complement each other, as follows:

Family Caregiver: A family caregiver is "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation." This definition is from the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act (Pub. L. 115-119).

Caregiver: A caregiver is “a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition.” This version is based on the CMS Outreach and Education definition.

To bill for caregiver training without the patient present, CMS indicates that caregivers must be trained by the patient’s treating clinician to assist with aspects of the patient’s care that are directly related to an established plan of care to address a diagnosed illness or injury.

CTS should not be billed for training medical professionals or support personnel who are employed to provide health care services to the patient.

Reasonable and Necessary CTS

CMS considers CTS to be reasonable and necessary when services are “integral to the patient’s overall treatment and furnished after the treatment plan (or therapy plan of care) is established.” They indicate that a plan of care should account for those clinical circumstances when the treating clinician determines that caregiver involvement is necessary to assist in carrying out a treatment plan to support successful outcomes for the patient. According to CMS, examples of patient conditions that may warrant CTS include, but are not limited to, “stroke, traumatic brain injury (TBI), dementia, autism spectrum disorders, individuals with other intellectual or cognitive disabilities, physical mobility limitations, or necessary use of assisted devices or mobility aids.”

CMS also notes the patient should agree to caregiver involvement and will require clinicians to document the patient’s or their representative’s specific consent for the caregiver(s) to receive training without the patient present.

Remote Therapeutic Monitoring (RTM) Services

SLPs have been able to provide and bill for RTM services under the MPFS since 2023. However, CMS waived certain billing requirements to allow broader patient access to care during the federal public health emergency (PHE). In this final rule, CMS clarifies that billing requirements for RTM services have changed with the end of the PHE. For example, RTM codes may only be billed when monitoring requires data collection for at least 16 days in a 30-day period. In addition, CMS notes that only one clinician may report the remote monitoring codes in a 30-day period and that RTM services may not be billed in conjunction with remote physiologic monitoring (RPM) codes.

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 2024 is **$2,330** 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

In the final rule, CMS implements the requirements of the Consolidated Appropriations Act of 2023 (CAA) by extending telehealth coverage of speech-language pathology services paid under the fee schedule through December 31, 2024. All CPT codes covered under the federal PHE will remain covered through the end of next year.

While there is technically a brief gap in guidance from CMS regarding telehealth coverage from October to the end of 2023, the agency highlighted in a frequently asked questions (FAQ) resource [PDF] that it would exercise enforcement discretion through the end of 2023 to allow the necessary regulations to be finalized for 2024. This FAQ applies enforcement discretion to all outpatient providers, including those in institutional settings like outpatient hospital departments. This means that providers in outpatient settings can continue to provide telehealth services to Medicare beneficiaries without interruption through the end of 2024. See Providing Audiology and Speech-Language Pathology Telehealth Services Under Medicare for more information.

ASHA remains committed to securing permanent authority for SLPs to receive reimbursement for services provided via telehealth at parity with payment for in-person services. SLPs can advocate for permanent Congressional authority to be telehealth providers under Medicare by urging Congress to support the Expanded Telehealth Access Act (H.R. 3875/S. 2880).

Telehealth Billing Changes

Although CMS plans to extend telehealth coverage through 2024 by continuing most PHE-era policies, including for institutional settings, the agency has finalized some changes to how telehealth services are billed on a claim beginning in 2024, as follows.

- Hospitals will use modifier “95” in addition to a hospital place of service (POS) code for outpatient telehealth services, aligning with current policy for other types of institutional providers.
- Therapy providers, including SLPs, will continue to use modifier “95” to indicate telehealth services and will not use one of the POS codes for telehealth services, regardless of settings. SLPs should continue to report the POS code that best reflects where services would have been provided in person.

In addition, CMS acknowledges that most clinicians providing telehealth services also maintain an in-person practice, so their expenses to provide telehealth services do not change significantly. As a result, CMS will continue paying for telehealth services in the patient’s home at the higher non-facility rate.

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 2024. 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 2024, which will be used to adjust their payments in 2026**. In addition, CMS will apply the promoting interoperability performance category to SLPs beginning in 2024.** Given the small number of SLPs subject to MIPS and additional exemptions specific to this category, ASHA does not anticipate this change will have significant implications for most members.

Because CMS has set exclusions and low-volume thresholds, a large majority of SLPs will be excluded from mandatory MIPS participation for 2024. 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 2026 Medicare payments for performance on the quality and improvement activities (IAs) performance categories in 2024. 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 2024, SLPs have eight applicable measures. This means that SLPs have the flexibility to select measures to meet the minimum reporting requirement of six measures. For additional information, CMS provides extensive resources on MIPS on its website.

- 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
- Measure 291: Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease **(New for 2024)**
- Measure 487: Screening for Social Drivers of Health **(New for 2024)**
- Measure 498: Connection to Community Service Provider **(New for 2024)**

For the IA performance category, SLPs must score a minimum of 40 points and attest to their completion via the CMS QPP website.

Advanced Alternative Payment Models (APMs)

Only a small percentage of SLPs participate in the APM track. These clinicians typically work for larger health systems and have the support of finance and administration departments to manage the complexity of such models.

This rule establishes digital measurements of quality called the Medicare Clinical Quality Measures (CQMs) for Accountable Care Organizations (ACOs) that are participating in the Medicare Shared Savings Program under the APM Performance Pathway as a new type of data collection. However, in addition to this new option to report quality data using Medicare CQMs, ACOs will continue to have the option to report quality data using the CMS Web Interface measures, electronic clinical quality measures (eCQMs), and/or MIPS CQMs collection types through 2024. In 2025, the CMS Web Interface measures will no longer be available and ACOs will have to report quality data using the eCQMs, MIPS CQMs, and/or Medicare CQMs.

The data completeness thresholds for Medicare CQMs are at least 75% for the 2024, 2025, and 2026 performance periods/2026, 2027, and 2028 MIPS payment years, respectively.

In an effort to streamline the administration of both programs and reduce administrative burden, standards for data completeness, benchmarking, and scoring of ACOs for the Medicare CQM collection type will align with MIPS benchmarking and scoring policies.

The Shared Savings Program's health equity adjustment will also be applied to an ACO's MIPS Quality performance category score when calculating shared savings payments, which advances equity by supporting ACOs that deliver high quality care while also serving a high proportion of underserved individuals.

To increase the number of patients in ACOs and improve access for underserved and high-complexity populations, multiple modifications were made to risk adjustment models, negative regional adjustments, and advanced investment payment policies.

2024 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 updated 2024 CF (**$33.2875**). The table also includes 2023 non-facility rates for comparison with 2024 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	2023 National Fee	2024 National Fee	Notes
31579	Laryngoscopy, flexible or rigid telescopic; with stroboscopy	$202.31	**$198.06**	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	$77.26	**$76.23**	SLPs may also use 92507 to report auditory (aural) rehabilitation.
92508	group, 2 or more individuals	$24.06	**$24.30**	See also: Medicare Guidelines for Group Therapy and Modes of Service Delivery for Speech-Language Pathology
92511	Nasopharyngoscopy with endoscope (separate procedure)	$119.96	**$117.17**	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)	$64.05	**$64.24**	
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	$86.07	**$87.55**	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	$134.19	**$132.82**	
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	$112.17	**$111.18**	Don't bill 92522 in conjunction with 92523.

Code	Descriptor	2023 National Fee	2024 National Fee	Notes
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	$230.09	**$227.69**	Don't bill 92523 in conjunction with 92522.
92524	Behavioral and qualitative analysis of voice and resonance	$110.81	**$109.52**	This procedure doesn't include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding	$85.73	**$84.55**	See also: Answers to Your Feeding/Swallowing Coding Questions
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	$72.52	**$72.23**	
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	$125.04	**$123.83**	See also: Billing for AAC and Device Documentation
92608	each additional 30 minutes (List separately in addition to code for primary procedure)	$49.14	**$48.60**	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	$104.37	**$103.19**	See also: Billing for AAC and Device Documentation
92610	Evaluation of oral and pharyngeal swallowing function	$85.73	**$85.22**	See also: Answers to Your Feeding/Swallowing Coding Questions
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	$92.51	**$91.87**	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;	$199.26	**$198.39**	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	$37.28	**$35.95**	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.

Code	Descriptor	2023 National Fee	2024 National Fee	Notes
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	$148.76	**$149.13**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act.
92615	interpretation and report only	$32.87	**$32.29**	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;	$227.04	**$228.35**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act.
92617	interpretation and report only	$41.00	**$40.28**	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	$87.77	**$85.88**	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)	$20.67	**$20.31**	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	$98.27	**$95.87**	

Code	Descriptor	2023 National Fee	2024 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	$126.74	**$123.83**	
96113	each additional 30 minutes (List separately in addition to code for primary procedure)	$59.98	**$59.92**	
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	$103.36	**$102.19**	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	$22.70	**$22.30**	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)	$21.69	**$21.30**	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	$64.39	**$62.25**	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	2023 National Fee	2024 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	$33.21	**$32.62**	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
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes	N/A	**$52.93**	**New in 2024.** See 2024 CPT Code Changes.
97551	each additional 15 minutes (List separately in addition to code for primary procedure)	N/A	**$26.30**	This is an add-on code to report in conjunction with 97550 for each additional 15 minutes of training.
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	N/A	**$22.30**	**New in 2024.** See 2024 CPT Code Changes.
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	$11.52	**$11.65**	See also: Use of CTBS Codes During COVID-19
98971	11-20 minutes	$20.33	**$20.64**	
98972	21 or more minutes	$31.18	**$30.62**	

Code	Descriptor	2023 National Fee	2024 National Fee	Notes
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment	$19.32	**$19.97**	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	$50.15	**$47.27**	
98977	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	$50.15	**$47.27**	
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**	See also: Speech-Language Pathology CPT and HCPCS Code Changes for 2023 and Use of CTBS Codes During COVID-19
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	$49.48	**$50.60**	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)	$39.65	**$39.95**	
G0451	Developmental testing, with interpretation and report, per standardized instrument form	$10.84	**$11.65**	This Medicare-specific HCPCS Level II code can be used in place of CPT 96110, which isn't paid by Medicare.

Code	Descriptor	2023 National Fee	2024 National Fee	Notes
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	$12.20	**$12.32**	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	$14.23	**$13.98**	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

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. 10) for services and procedures SLPs may bill directly to Medicare.

Code	Descriptor	2024 National Fee	Notes
31575	Laryngoscopy, flexible; diagnostic	**$129.16**	This procedure is for medical diagnosis by a physician.
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	**$109.18**	This is a radiology code.
74230	Swallowing function, with cineradiography/videoradiography	**$124.50**	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	**$110.18**	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	**$90.21**	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)	**$31.62**	*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	**$78.23**	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.

Code	Descriptor	2024 National Fee	Notes
96110	Developmental screening, with interpretation and report, per standardized instrument form	**$11.65**	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	**$29.29**	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	**$33.62**	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)	**$17.98**	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	**$36.62**	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		**$26.30**	CMS won't pay for this code when reported by an SLP.

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. 10). For geographically adjusted RVUs, go to Addendum E in the CMS CY 2024 PFS Final Rule Addenda [ZIP] files.

Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
31579	1.88	3.82	0.25	5.95
92507	1.30	0.96	0.03	2.29
92508	0.33	0.39	0.01	0.73
92511	0.61	2.87	0.04	3.52
92512	0.55	1.34	0.04	1.93
92520	0.75	1.85	0.03	2.63
92521	2.24	1.69	0.06	3.99
92522	1.92	1.35	0.07	3.34
92523	3.84	2.90	0.10	6.84
92524	1.92	1.30	0.07	3.29
92526	1.34	1.17	0.03	2.54
92597	1.26	0.87	0.04	2.17
92607	1.85	1.82	0.05	3.72
92608	0.70	0.74	0.02	1.46
92609	1.50	1.56	0.04	3.10
92610	1.30	1.22	0.04	2.56
92611	1.34	1.35	0.07	2.76
92612	1.27	4.63	0.06	5.96
92613	0.71	0.33	0.04	1.08
92614	1.27	3.14	0.07	4.48
92615	0.63	0.30	0.04	0.97
92616	1.88	4.88	0.10	6.86
92617	0.79	0.37	0.05	1.21
92626	1.40	1.14	0.04	2.58
92627	0.33	0.27	0.01	0.61
96105	1.75	1.06	0.07	2.88
96112	2.56	1.01	0.15	3.72
96113	1.16	0.57	0.07	1.80
96125	1.70	1.31	0.06	3.07
97129	0.50	0.16	0.01	0.67
97130	0.48	0.15	0.01	0.64
97533	0.48	1.38	0.01	1.87
97535	0.45	0.52	0.01	0.98
97550	1.00	0.56	0.03	1.59
97551	0.54	0.24	0.01	0.79

Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
97552	0.23	0.43	0.01	0.67
98970	0.25	0.09	0.01	0.35
98971	0.44	0.16	0.02	0.62
98972	0.69	0.21	0.02	0.92
98975	0.00	0.58	0.02	0.60
98976	0.00	1.41	0.01	1.42
98977	0.00	1.41	0.01	1.42
98980	0.62	0.86	0.04	1.52
98981	0.61	0.55	0.04	1.20
G0451	0.00	0.34	0.01	0.35
G2250	0.18	0.18	0.01	0.37
G2251	0.25	0.15	0.02	0.42

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