2024

Medicare Fee Schedule for Audiologists

ASHA
Audiology
Dedicated to Advancing
the Profession of Audiology

621051

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 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. 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)

Table of Contents

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 in the Medicare Access and CHIP Reauthorization Act of 2015. Additional payment adjustments—based on legislative actions, or 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 audiologists providing services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include coding updates; access to audiology services without a physician order; quality reporting; APMs; 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. 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 audiologists.

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—audiologists 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 audiologists 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 for Audiology Services

CMS's regulatory impact analysis (RIA) of the final rule estimates that audiology services will see a cumulative 2% decrease in payments. The analysis also shows that most individual audiologists will experience between a negative 2% to a negative 5% shift in payment in 2024 in *addition* to the cut to 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, including this year. ASHA continues to advocate for legislation to address these annual reductions and ensure audiologists 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 audiology spending under the MPFS. However, it may not reflect the changes experienced by individual audiologists or practices, as actual payment depends on several factors, including locality-specific rates and the CPT codes billed. For example, CPT code 92557 (comprehensive audiometry) will see a 4% decrease to the national payment rate while CPT code 92546 (sinusoidal vertical axis rotational testing) will experience a 1% increase. As a result, audiologists 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. 8) for a listing of audiology-related procedures and corresponding national payment rates. The table also includes 2023 non-facility rates for comparison with the updated 2024 rates to help audiologists 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 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 2024 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 rarely change over time, unlike practice expense values that fluctuate according to CMS payment formula policies. This effort is ongoing, leaving some codes with only practice expense and malpractice components. ASHA is working 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].

New CPT Codes for Auditory Osseointegrated Device (AOD) Services

Effective January 1, 2024, audiologists will see two new timed codes describing the first hour (CPT code 92622) and each subsequent 15 minutes of time (CPT code 92623) for the analysis, programming, and verification of an auditory osseointegrated sound processor. These codes can also be used for subsequent reprogramming of the AOD. CMS also adds both codes to the list of services that can be billed with an "AB" modifier when performed by an audiologist without a physician referral for a nonacute hearing condition. ASHA's website provides additional details regarding the 2024 coding updates.

See Table 1 (p. 8) for the full descriptors and corresponding national payment rates for 92622 and 92623.

Access to Audiology Services Without a Physician Order

In 2023, CMS implemented a policy that allows audiologists to provide nonacute hearing assessment services—under limited circumstances—without a physician order. No substantive changes were made to this policy with the exception of adding two CPT codes to the list of services that can be billed without an order using the "AB" modifier—92622 and 92623—bringing the total number of services that can be provided under the limitations of the policy to 38 CPT codes. More details regarding this policy can be found on the ASHA website.

ASHA continues to monitor the implementation of this policy and to advocate for improvements. In addition, ASHA supports legislation that would improve the Medicare audiology benefit to include removal of the physician order requirement, coverage of both assessment and treatment services, and reclassifying audiologists as "practitioners" which would allow them to bill for telehealth services on a permanent basis.

Audiologists can take action by contacting their members of Congress today to encourage them to cosponsor the Medicare Audiology Access Improvement Act (H.R. 6445/S. 2377).

Medicare Telehealth Services

In the final rule, CMS implements the requirements of the Consolidated Appropriations Act of 2023 (CAA) by extending telehealth coverage of audiology 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 was 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 audiologists to receive reimbursement for services provided via telehealth at parity with payment for in-person services. Audiologists 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.
- Audiologists will no longer use modifier “95” and will instead use POS “10” when providing telehealth services in the patient’s home or POS “02” when the patient is at a location other than their home, such as a satellite office or other facility.

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 when billed with POS “10” at the higher non-facility rate. All other claims billed with POS “02” will be paid at the lower 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. Audiologists first became eligible for MIPS in 2019 and will continue to participate in the program in 2024. 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 2024, which will be used to adjust their payments in 2026. **In addition, CMS will apply the promoting interoperability performance category to audiologists beginning in 2024.** Given the small number of audiologists 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 audiologists 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 audiologists—must report a minimum of six measures when/if six measures apply. In 2024, audiologists have 12 potentially applicable measures as CMS will maintain the 10 measures in the audiology specialty measure set and add two new measures for the 2024 performance/2026 payment year. This provides audiologists with the flexibility to select six measures from the 12 options for reporting. 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 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
- Measure 431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling
- Measure 487: Screening for Social Drivers of Health
- Measure 317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented **(New for 2024)**
- Measure 498: Connection to Community Service Provider: Percent of patients 18 years or older who screen positive for one or more of the following health-related social needs (HRSNs) **(New for 2024)**

For the IA performance category, audiologists 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 audiologists 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 Audiology Services

Table 1. National Medicare Part B Rates for Audiology Services

The following table contains full descriptors and national payment rates for audiology-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 audiologists estimate the impact of the payment cuts. 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	2023 National Fee	2024 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92517		Vestibular evoked myogenic potential testing, with interpretation and report; cervical (cVEMP)	$78.28	**$76.89**	**$41.61**	
92518		ocular (oVEMP)	$80.99	**$77.89**	**$42.28**	
92519		cervical (cVEMP) and ocular (oVEMP)	$134.53	**$127.16**	**$62.58**	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.
92537		Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	$40.66	**$39.61**	**N/A**	
92537	TC	bithermal...	$9.83	**$9.32**	**N/A**	
92537	26	bithermal...	$30.84	**$30.29**	**$30.29**	
92538		monothermal (ie, one irrigation in each ear for a total of two irrigations)	$22.70	**$22.30**	**N/A**	

Code	Mod	Descriptor	2023 National Fee *Non-Facility*	2024 National Fee		Notes
				Non-Facility	*Facility*	
92538	TC	monothermal...	$6.78	**$6.66**	**N/A**	
92538	26	monothermal...	$15.93	**$15.65**	**$15.65**	
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	$109.79	**$106.52**	**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…	$32.19	**$30.96**	**N/A**	
92540	26	Basic vestibular evaluation…	$77.60	**$75.56**	**$75.56**	
92541		Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	$25.42	**$24.97**	**N/A**	
92541	TC	Spontaneous nystagmus test…	$4.41	**$4.33**	**N/A**	
92541	26	Spontaneous nystagmus test…	$21.01	**$20.64**	**$20.64**	
92542		Positional nystagmus test, minimum of 4 positions, with recording	$29.14	**$28.63**	**N/A**	
92542	TC	Positional nystagmus test…	$4.41	**$4.33**	**N/A**	
92542	26	Positional nystagmus test…	$24.74	**$24.30**	**$24.30**	
92544		Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	$17.96	**$17.64**	**N/A**	
92544	TC	Optokinetic nystagmus test…	$3.73	**$3.66**	**N/A**	
92544	26	Optokinetic nystagmus test…	$14.23	**$13.98**	**$13.98**	
92545		Oscillating tracking test, with recording	$16.94	**$16.64**	**N/A**	
92545	TC	Oscillating tracking test…	$3.73	**$3.66**	**N/A**	
92545	26	Oscillating tracking test…	$13.22	**$12.98**	**$12.98**	
92546		Sinusoidal vertical axis rotational testing	$128.43	**$132.48**	**N/A**	

Code	Mod	Descriptor	2023 National Fee *Non-Facility*	2024 National Fee		Notes
				Non-Facility	*Facility*	
92546	TC	Sinusoidal vertical axis rotational testing	$113.52	**$117.84**	**N/A**	
92546	26	Sinusoidal vertical axis rotational testing	$14.91	**$14.65**	**$14.65**	
92547		Use of vertical electrodes (List separately in addition to code for primary procedure)	$10.84	**$10.65**	**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)	$47.78	**$46.94**	**N/A**	
92548	TC	CDP-SOT	$14.23	**$13.98**	**N/A**	
92548	26	CDP-SOT	$33.55	**$32.95**	**$32.95**	
92549		with motor control test (MCT) and adaptation test (ADT)	$65.40	**$64.24**	**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	$20.67	**$20.31**	**N/A**	
92549	26	with MCT and ADT	$44.73	**$43.94**	**$43.94**	
92550		Tympanometry and reflex threshold measurements	$22.37	**$21.64**	**N/A**	Report 92550 when performing both tympanometry 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	$35.92	**$37.95**	**N/A**	
92553		air and bone	$44.05	**$45.94**	**N/A**	
92555		Speech audiometry threshold;	$27.79	**$28.96**	**N/A**	
92556		with speech recognition	$43.04	**$44.94**	**N/A**	

Code	Mod	Descriptor	2023 National Fee *Non-Facility*	2024 National Fee		Notes
				Non-Facility	*Facility*	
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	$37.28	**$36.28**	**$31.29**	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.
92562		Loudness balance test, alternate binaural or monaural	$48.46	**$48.27**	**N/A**	
92563		Tone decay test	$33.55	**$34.62**	**N/A**	
92565		Stenger test, pure tone	$20.33	**$20.97**	**N/A**	
92567		Tympanometry (impedance testing)	$16.60	**$16.31**	**$10.65**	
92568		Acoustic reflex testing, threshold	$15.59	**$14.98**	**$14.65**	
92570		Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	$32.53	**$31.96**	**$28.63**	Don't bill 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	$30.50	**$30.96**	**N/A**	
92572		Staggered spondaic word test	$47.78	**$53.26**	**N/A**	
92575		Sensorineural acuity level test	$75.57	**$73.90**	**N/A**	
92576		Synthetic sentence identification test	$40.33	**$42.61**	**N/A**	
92577		Stenger test, speech	$20.67	**$21.97**	**N/A**	
92579		Visual reinforcement audiometry (VRA)	$45.41	**$43.94**	**$36.28**	
92582		Conditioning play audiometry	$83.02	**$86.55**	**N/A**	
92583		Select picture audiometry	$54.90	**$56.92**	**N/A**	
92584		Electrocochleography	$114.54	**$110.51**	**N/A**	

Code	Mod	Descriptor	2023 National Fee *Non-Facility*	2024 National Fee		Notes
				Non-Facility	*Facility*	
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	$22.03	**$21.30**	**N/A**	See also: CPT Coding for Otoacoustic Emissions
92587	TC	Distortion product evoked otoacoustic emissions…limited	$4.07	**$3.66**	**N/A**	
92587	26	Distortion product evoked otoacoustic emissions…limited	$17.96	**$17.64**	**$17.64**	
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	$34.23	**$32.95**	**N/A**	See also: CPT Coding for Otoacoustic Emissions
92588	TC	Distortion product evoked otoacoustic emissions…comprehensive	$5.42	**$4.99**	**N/A**	
92588	26	Distortion product evoked otoacoustic emissions…comprehensive	$28.80	**$27.96**	**$27.96**	
92596		Ear protector attenuation measurements	$74.21	**$76.89**	**N/A**	
92601		Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	$162.66	**$157.78**	**$120.50**	
92602		subsequent reprogramming	$103.02	**$99.20**	**$67.91**	
92603		Diagnostic analysis of cochlear implant, age 7 years or older; with programming	$152.49	**$148.13**	**$117.17**	
92604		subsequent reprogramming	$92.17	**$89.21**	**$64.91**	
92620		Evaluation of central auditory function, with report; initial 60 minutes	$89.46	**$87.88**	**$77.89**	

Code	Mod	Descriptor	2023 National Fee *Non-Facility*	2024 National Fee		Notes
				Non-Facility	*Facility*	
92621		each additional 15 minutes (List separately in addition to code for primary procedure)	$22.03	**$21.64**	**$18.31**	This is an add-on code to report in conjunction with 92620 for each additional 15 minutes of evaluation.
92622		Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	N/A	**$78.89**	**$65.24**	**New in 2024**. See CPT Code Changes for 2024 for more information.
92623		each additional 15 minutes (List separately in addition to code for primary procedure)	N/A	**$20.31**	**$17.31**	This is an add-on code to report in conjunction with 92622 for each additional 15 minutes of time.
92625		Assessment of tinnitus (includes pitch, loudness matching, and masking)	$68.79	**$66.91**	**$59.92**	
92626		Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); first hour	$87.77	**$85.88**	**$73.23**	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**	**$17.31**	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	$110.81	**$107.85**	**$91.87**	

Code	Mod	Descriptor	2023 National Fee *Non-Facility*	2024 National Fee		Notes
				Non-Facility	*Facility*	
92651		Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	$85.73	**$82.55**	**N/A**	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. See also: Audiology CPT and HCPCS Code Changes for 2021
92652		for threshold estimation at multiple frequencies, with interpretation and report	$114.54	**$111.85**	**N/A**	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. See also: Audiology CPT and HCPCS Code Changes for 2021

Code	Mod	Descriptor	2023 National Fee *Non-Facility*	2024 National Fee		Notes
				Non-Facility	*Facility*	
92653		neurodiagnostic, with interpretation and report	$85.40	**$82.89**	**N/A**	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. See also: Audiology CPT and HCPCS Code Changes for 2021
92700		Unlisted otorhinolaryngological service or procedure	MAC priced	**MAC priced**	**MAC priced**	See also: New Procedures...But No Codes

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

Audiologists may not directly bill Medicare for the procedures listed in this table because CMS reimburses audiologists only for diagnostic hearing and balance services. Although they are within the scope of practice of an 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 audiologist's NPI and may *not* be billed "incident to" a physician (i.e., under the physician's NPI).

Code	Mod	Descriptor	2024 National Fee		Notes
			Non-Facility	*Facility*	
69209		Removal impacted cerumen using irrigation/lavage, unilateral	**$15.98**	**N/A**	Not covered under the audiology benefit.
69210		Removal impacted cerumen requiring instrumentation, unilateral (for bilateral procedure, report 69210)	**$47.93**	**$32.29**	Not covered under the audiology benefit.
92516		Facial nerve function studies (eg, electroneuronography)	**$72.23**	**$22.30**	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	**$12.65**	**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	**$9.32**	**$8.32**	Medicare doesn't cover screenings, but rates are published as reference, when available.
92590		Hearing aid examination and selection; monaural	**$0.00**	**$0.00**	Medicare doesn't cover services related to hearing aids.
92591		binaural	**$0.00**	**$0.00**	
92592		Hearing aid check; monaural	**$0.00**	**$0.00**	
92593		binaural	**$0.00**	**$0.00**	

Code	Mod	Descriptor	2024 National Fee		Notes
			Non-Facility	*Facility*	
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	**$26.96**	**N/A**	Medicare doesn't cover screenings, but rates are published as reference, when available. See also: Audiology CPT and HCPCS Code Changes for 2021
95907		Nerve conduction studies; 1–2 studies	**$89.88**	**N/A**	Covered under physician supervision.
95907	TC	1–2 studies	**$38.61**	**N/A**	
95907	26	1–2 studies	**$51.60**	**$51.60**	
95908		Nerve conduction studies; 3–4 studies	**$111.51**	**N/A**	Covered under physician supervision.
95908	TC	3–4 studies	**$46.94**	**N/A**	
95908	26	3–4 studies	**$64.58**	**$64.58**	
95909		Nerve conduction studies; 5–6 studies	**$133.82**	**N/A**	Covered under physician supervision.
95909	TC	5–6 studies	**$56.59**	**N/A**	
95909	26	5–6 studies	**$77.23**	**$77.23**	
95910		Nerve conduction studies; 7–8 studies	**$174.76**	**N/A**	Covered under physician supervision.
95910	TC	7–8 studies	**$71.90**	**N/A**	
95910	26	7–8 studies	**$102.86**	**$102.86**	
95911		Nerve conduction studies; 9–10 studies	**$210.71**	**N/A**	Covered under physician supervision.
95911	TC	9–10 studies	**$82.22**	**N/A**	
95911	26	9–10 studies	**$128.49**	**$128.49**	
95912		Nerve conduction studies; 11–12 studies	**$246.33**	**N/A**	Covered under physician supervision.
95912	TC	11–12 studies	**$92.87**	**N/A**	
95912	26	11–12 studies	**$153.46**	**$153.46**	
95913		Nerve conduction studies; 13 or more studies	**$284.28**	**N/A**	Covered under physician supervision.
95913	TC	13 or more studies	**$102.86**	**N/A**	

Code	Mod	Descriptor	2024 National Fee		Notes
			Non-Facility	*Facility*	
95913	26	13 or more studies	**$181.42**	**$181.42**	
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	**$172.89**	**N/A**	Covered under physician supervision.
95925	TC	in upper limbs	**$175.76**	**N/A**	
95925	26	in upper limbs	**$148.46**	**$27.30**	
95926		in lower limbs	**$27.30**	**N/A**	Covered under physician supervision.
95926	TC	in lower limbs	**$157.45**	**N/A**	
95926	26	in lower limbs	**$130.82**	**$26.63**	
95938*		in upper and lower limbs	**$374.48**	**N/A**	*Out of numerical order. Covered under physician supervision.
95938	TC	in upper and lower limbs	**$330.21**	**N/A**	
95938	26	in upper and lower limbs	**$44.27**	**$44.27**	
95927		in the trunk or head	**$182.08**	**N/A**	Covered under physician supervision.
95927	TC	in the trunk or head	**$155.45**	**N/A**	
95927	26	in the trunk or head	**$26.63**	**$26.63**	
95930		Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	**$67.24**	**N/A**	Covered under physician supervision.
95930	TC	checkerboard or flash	**$49.27**	**N/A**	
95930	26	checkerboard or flash	**$17.98**	**$17.98**	
95937		Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	**$103.86**	**N/A**	Covered under physician supervision.
95937	TC	Neuromuscular junction testing…	**$70.24**	**N/A**	
95937	26	Neuromuscular junction testing…	**$33.62**	**$33.62**	
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**	**$31.62**	Covered under physician supervision.

Code	Mod	Descriptor	2024 National Fee		Notes
			Non-Facility	*Facility*	
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) (eg, Epley maneuver, Semont maneuver), per day	**$42.28**	**$35.28**	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	**$11.65**	**$11.65**	Not covered under the audiology benefit. See also: Use of CTBS Codes During COVID-19
98971		11-20 minutes	**$20.64**	**$20.64**	See note for 98970.
98972		21 or more minutes	**$30.62**	**$30.29**	
98975		Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment	**$19.97**	**N/A**	Not covered under the audiology benefit. 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	**$47.27**	**N/A**	
98977		device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	**$47.27**	**N/A**	
98978		device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	**MAC priced**	**MAC priced**	**New in 2023.** Not covered under the audiology benefit. See also: Audiology CPT and HCPCS Code Changes for 2023 and Use of CTBS Codes During COVID-19

Code	Mod	Descriptor	2024 National Fee		Notes
			Non-Facility	*Facility*	
98980		Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes	**$50.60**	**$30.29**	Not covered under the audiology benefit. See also: Use of CTBS Codes During COVID-19
98981		each additional 20 minutes (listed separately in addition to code for primary procedure)	**$39.95**	**$29.96**	
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**	**$31.62**	Covered under physician supervision.
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	**$12.32**	**$8.99**	Not covered under the audiology benefit. 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	**$13.98**	**$12.65**	Not covered under the audiology benefit. See also: Use of CTBS Codes During COVID-19

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

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 2024 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	0.03	1.48	2.31	0.42	1.25
92518		0.80	0.05	1.49	2.34	0.42	1.27
92519		1.20	0.04	2.58	3.82	0.64	1.88
92537		0.60	0.02	0.57	1.19	N/A	N/A
92537	TC	0.00	0.01	0.27	0.28	N/A	N/A
92537	26	0.60	0.01	0.30	0.91	0.30	0.91
92538		0.30	0.02	0.35	0.67	N/A	N/A
92538	TC	0.00	0.01	0.19	0.20	N/A	N/A
92538	26	0.30	0.01	0.16	0.47	0.16	0.47
92540		1.50	0.03	1.67	3.20	N/A	N/A
92540	TC	0.00	0.01	0.92	0.93	N/A	N/A
92540	26	1.50	0.02	0.75	2.27	0.75	2.27
92541		0.40	0.02	0.33	0.75	N/A	N/A
92541	TC	0.00	0.01	0.12	0.13	N/A	N/A
92541	26	0.40	0.01	0.21	0.62	0.21	0.62
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	0.23	0.50	N/A	N/A
92545	TC	0.00	0.01	0.10	0.11	N/A	N/A
92545	26	0.25	0.01	0.13	0.39	0.13	0.39
92546		0.29	0.03	3.66	3.98	N/A	N/A
92546	TC	0.00	0.02	3.52	3.54	N/A	N/A
92546	26	0.29	0.01	0.14	0.44	0.14	0.44
92547		0.00	0.00	0.32	0.32	N/A	N/A
92548		0.67	0.03	0.71	1.41	N/A	N/A
92548	TC	0.00	0.01	0.41	0.42	N/A	N/A
92548	26	0.67	0.02	0.30	0.99	0.30	0.99
92549		0.87	0.02	1.04	1.93	N/A	N/A
92549	TC	0.00	0.01	0.60	0.61	N/A	N/A
92549	26	0.87	0.01	0.44	1.32	0.44	1.32
92550		0.35	0.01	0.29	0.65	N/A	N/A

Code	Mod	Professional Work	Malpractice	Non-Facility Practice Expense	Non-Facility Total	Facility Practice Expense	Facility Total
92552		0.00	0.01	1.13	1.14	N/A	N/A
92553		0.00	0.01	1.37	1.38	N/A	N/A
92555		0.00	0.01	0.86	0.87	N/A	N/A
92556		0.00	0.01	1.34	1.35	N/A	N/A
92557		0.60	0.02	0.47	1.09	0.32	0.94
92562		0.00	0.01	1.44	1.45	N/A	N/A
92563		0.00	0.01	1.03	1.04	N/A	N/A
92565		0.00	0.01	0.62	0.63	N/A	N/A
92567		0.20	0.01	0.28	0.49	0.11	0.32
92568		0.29	0.01	0.15	0.45	0.14	0.44
92570		0.55	0.02	0.39	0.96	0.29	0.86
92571		0.00	0.01	0.92	0.93	N/A	N/A
92572		0.00	0.01	1.59	1.60	N/A	N/A
92575		0.00	0.02	2.20	2.22	N/A	N/A
92576		0.00	0.01	1.27	1.28	N/A	N/A
92577		0.00	0.01	0.65	0.66	N/A	N/A
92579		0.70	0.02	0.60	1.32	0.37	1.09
92582		0.00	0.01	2.59	2.60	N/A	N/A
92583		0.00	0.01	1.70	1.71	N/A	N/A
92584		1.00	0.04	2.28	3.32	N/A	N/A
92587		0.35	0.02	0.27	0.64	N/A	N/A
92587	TC	0.00	0.01	0.10	0.11	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	0.99	N/A	N/A
92588	TC	0.00	0.01	0.14	0.15	N/A	N/A
92588	26	0.55	0.01	0.28	0.84	0.28	0.84
92596		0.00	0.01	2.30	2.31	N/A	N/A
92601		2.30	0.06	2.38	4.74	1.26	3.62
92602		1.30	0.03	1.65	2.98	0.71	2.04
92603		2.25	0.06	2.14	4.45	1.21	3.52
92604		1.25	0.03	1.40	2.68	0.67	1.95
92620		1.50	0.05	1.09	2.64	0.79	2.34
92621		0.35	0.01	0.29	0.65	0.19	0.55
92622		1.25	0.03	1.09	2.37	0.68	1.96
92623		0.33	0.01	0.27	0.61	0.18	0.52
92625		1.15	0.04	0.82	2.01	0.62	1.80
92626		1.40	0.04	1.14	2.58	0.77	2.20
92627		0.33	0.01	0.27	0.61	0.18	0.52
92640		1.76	0.04	1.44	3.24	0.96	2.76
92651		1.00	0.05	1.43	2.48	N/A	N/A
92652		1.50	0.08	1.78	3.36	N/A	N/A
92653		1.05	0.06	1.38	2.49	N/A	N/A

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. In most cases, services provided by an audiologist will be paid at the global value when both testing, 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.

ASHA
American
Speech-Language-Hearing
Association