2025

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 2025 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 payment and coding rules. If you have any questions, contact reimbursement@asha.org.

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Overview

Outpatient speech-language pathology services provided under Part B of the Medicare program are paid under the Medicare Physician Fee Schedule (MPFS). Congress approves annual payment updates to the MPFS, which are frozen at 0.0% from 2020 through 2025 because of a provision in the Medicare Access and CHIP Reauthorization Act of 2015. Additional payment adjustments—based on legislative actions, participation in the Merit-based Incentive Payment System (MIPS), or Advanced Alternative Payment Models (APMs)—may also apply.

Rates associated with individual Current Procedural Terminology (CPT®) codes may continue to fluctuate due to adjustments to professional work, practice expense, and malpractice insurance values that are part of the fee calculation. In addition, the Centers for Medicare & Medicaid Services (CMS) may request a review and revaluation of certain codes that are flagged as potentially misvalued services.

This document includes regulations and rates for implementation on January 1, 2025, 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 2025 Medicare Physician Fee Schedule (MPFS)

ASHA reviewed relevant sections of the 2025 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 2025. These cuts have gone into effect each year since 2021due 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 for 2025 and to seek long-term solutions to fix the Medicare outpatient payment system. This ongoing advocacy is necessary to mitigate the anticipated payment reduction, which could be as high as 9%. ASHA members should prepare for the possibility the reduction will go into effect January 1, 2025. Although Congress has mitigated these cuts the past several years, policy and political dynamics may push potential action to next year, after the cuts take effect. ASHA will continue to monitor and provide updates as the situation evolves.

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) 2025 CF of **$32.35**, representing a 2.8% decrease from the $33.29 CF for 2024. Although CMS included a 0.02% positive budget neutrality adjustment, the decrease in the CF is mostly due to expiration of the temporary 2.93% positive adjustment that Congress implemented to temporarily mitigate significant payment cuts in 2024.

Payment Changes to Speech-Language Pathology Services

CMS also provides a regulatory impact analysis (RIA), which estimates cumulative payment changes for providers *in addition* to the CF cut. For 2025, it's estimated that SLPs will see a cumulative 0% additional change in payments based on policy changes. However, the analysis also shows that most SLPs will experience between a negative 1% to a positive 1% shift in payment in 2025 in *addition* to the CF adjustment.

Medicare providers also face other Medicare cuts known as sequestration (2% reduction) and statutory "Pay-As-You-Go," or PAYGO (4% reduction). Without congressional action, this could result in a total cut of about 9% 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.

The estimated impacts calculated by CMS reflect average payments based on cumulative therapy spending under the MPFS. However, they 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 2% decrease to the national payment rate while CPT code 92520 (laryngeal function studies) will experience a 0% change. As a result, to determine the actual impact of the payment changes on their practice, SLPs 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 2024 nonfacility rates for comparison with 2025 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 2025 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 2025. 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 2025 MPFS. ASHA's website provides more information on 2025 coding updates.

Caregiver Training Without the Patient Present

Beginning in 2024, SLPs have been able to bill CPT codes 97550-97552 to **report CTS without the patient present** when provided under an established, individualized, and patient-centered plan of care to facilitate a patient's functional performance. The final rule includes refinements to the existing CTS policies. CMS confirms that SLPs can obtain verbal consent from the patient or patient representative for CTS. In addition, it added CPT codes 97550-97552 to the temporarily authorized telehealth services list for 2025. However, this new addition may not be useful without congressional action to extend coverage to SLPs for telehealth services beyond the end of 2024. See ASHA's website for more information on Medicare telehealth coverage for SLPs.

New Caregiver Training G-Codes for Primary Care Services

CMS finalized a new set of Medicare-specific G-codes for caregiver training without the patient present in direct care strategies and techniques to support care for patients with ongoing conditions or illness and to reduce complications. These are similar in structure to the existing CTS codes available for SLPs and valued at the same rate.

CMS designated direct care CTS as a "sometimes therapy" service when personally furnished by an SLP. This means that SLPs can report these codes when the caregiver training provided is **not** intended to facilitate *functional performance* of the patient but to support care of the patient by preventing adverse health events such as, but not limited to, infections and monitoring for potential complications. **SLPs will continue to use CPT codes 97550, 97551, and 97552 when caregiver training provided is directly related to functional performance of the patient.**

The following new codes are effective beginning January 1, 2025. These G-codes are Medicare-specific. Other payers may add them to their fee schedules, but it is important to check with them directly before billing these codes.

G0541 Caregiver training in direct care strategies and techniques to support care for patients with ongoing conditions or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes

G0542 Caregiver training in direct care strategies and techniques to support care for patients with ongoing conditions or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use G0542 in conjunction with G0541)

G0543 Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers

SLPs should keep in mind that services reported using these G-codes are distinctly different from CPT codes 97550-97552, which focus on caregiver training to support a patient's functional performance. These G-codes should only be reported for those times when an SLP may be providing training without the patient present to provide caregiver(s) with strategies to help reduce complications. This training should not be associated with goals related to a patient's functional performance. In addition, the

services described by the new G-codes must be incorporated into the patient's plan of care. If a patient is already under a therapy plan of care, this may be as simple as updating and recertifying the plan of care. However, CMS hasn't provided guidance in those instances when a patient isn't currently under a therapy plan of care but has been referred to the SLP for services that could be billed under the new G-codes.

ASHA will seek further clarification from CMS on the use of these new G-codes by SLPs as "sometime therapy" codes and how they are to be reflected in a plan of care. We will update members as guidance becomes available.

More details on the new G-codes, including examples of situations when an SLP might provide these types of services, are available on ASHA's website.

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 2025 is **$2,410** for physical therapy and speech-language pathology services combined. ASHA's website provides more information regarding the targeted manual medical review process.

Medicare Telehealth Services

In the final rule, CMS clarified that the CPT codes SLPs use will continue to be covered telehealth services in 2025. However, Congress needs to pass legislation to temporarily or permanently extend telehealth coverage for nonphysician clinicians such as SLPs. If Congress fails to act, SLPs can enter into private pay arrangements with Medicare beneficiaries for telehealth services. 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

ASHA was pleased to see that several telehealth-related changes were finalized for 2025. CMS will continue to allow clinicians who are providing telehealth services to Medicare beneficiaries from their homes to use their business address on claims to protect their privacy and security. CMS will also permanently allow two-way, real-time audio-only communication technology to qualify as a telehealth service furnished to a beneficiary in their home if the clinician is technically capable of using audio and video equipment that enables two-way, real-time interactive communication, but the patient is not capable of, or does not consent to, the use of video technology. To use this flexibility, clinicians in outpatient settings will be required to report modifier "93" (audio-only synchronous telemedicine service) on the claim to verify that these conditions have been met.

Telesupervision of "Incident To" Services

SLPs, physical therapists (PTs), and occupational therapists (OTs) are allowed to provide services "incident to" a physician with direct supervision. "Incident to" coverage policies state that the services of the therapist would be billed under the National Provider Identifier (NPI) of the supervising physician. Direct supervision is typically defined as *in the office suite and immediately available to help if needed*.

This definition was relaxed during the COVID-19 public health emergency to allow for telesupervision—supervision via real-time audio and visual interactive telecommunications.

CMS will continue to allow telesupervision through 2025 for physical and occupational therapy and speech-language pathology services.

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 2025. If an SLP meets the criteria for a MIPS eligible clinician, they will need to report data associated with quality measures, promoting interoperability, and improvement activities in 2025, which will be used to adjust their payments in 2027**.**

Because CMS has set exclusions and low-volume thresholds, a large majority of SLPs will be excluded from mandatory MIPS participation for 2025. MIPS only applies to clinicians in outpatient nonfacility settings. In addition, clinicians must meet **ALL** of the following criteria to be required to participate:

- Bill $90,000 or more in allowed charges to the Medicare program for professional services;
- 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 2027 Medicare payments for performance on the quality, promoting interoperability, and improvement activities (IAs) performance categories in 2025. 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 2025, SLPs have 13 applicable measures with the addition of five new measures as requested by ASHA. 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.

Existing Measures

- 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
- Measure 487: Screening for Social Drivers of Health
- Measure 498: Connection to Community Service Provider

New Measures for 2025

- Dementia: Cognitive Assessment: Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.
- Dementia: Functional Status Assessment: Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.
- Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia: Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety concerns screening in two domains of risk: (1) dangerousness to self or others and (2) environmental risks; and if safety concerns screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.
- Dementia: Education and Support of Caregivers for Patients with Dementia: Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months.
- Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences: Percentage of patients diagnosed with ALS who were offered assistance in planning for end of life issues (e.g., advance directives, invasive ventilation, lawful physician-hastened death, hospice) or whose existing end of life plan was reviewed or updated at least once annually or more frequency as clinically indicated (i.e., rapid progression).

CMS eliminated the weighting (e.g., medium, high) associated with IAs. For the IA performance category, SLPs must complete two activities 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 care systems and have the support of finance and administration departments to manage the complexity of such models. The final rule added new quality measures and rewards efforts to improve health equity. SLPs working for organizations participating in APMs can help their organizations earn incentive payments by engaging in quality improvement efforts.

To incentivize accountable care organizations (ACOs) to serve more beneficiaries from underserved communities, CMS finalized a Health Equity Benchmark Adjustment (HEBA) to be applied based on the number of beneficiaries they serve who are dually eligible or enrolled in the Medicare Part D Low-Income Subsidy (LIS).

CMS is also requiring ACOs to report the APM Performance Pathway (APP) Plus Quality Measure Set. This includes the six measures currently in the APP quality measure set and incrementally incorporate the remaining five Adult Universal Foundation quality measures by the 2028 performance period/2030 payment year with preference for reporting electronically through electronic clinical quality measures (eCQMs).

New measures included in the APP Plus Quality Measure Set for Shared Savings Program ACOs that could involve SLPs include:

- #479 Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups beginning in PY 2025
- #484 Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients With Multiple Chronic Conditions Beginning PY 2026 (claims-based measure)
- #487 Screening for Social Drivers of Health beginning in PY 2028.

CMS also finalized a new calculation methodology to account for the impact of improper payments when reopening a payment determination to recoup payments it believes were not properly earned.

2025 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 2025 CF (**$32.3465**). The table also includes 2024 nonfacility rates for comparison with 2025 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 nonfacility 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	2024 National Fee	2025 National Fee	Notes
31579	Laryngoscopy, flexible or rigid telescopic; with stroboscopy	$198.06	**$190.52**	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	$76.23	**$75.04**	SLPs may also use 92507 to report auditory (aural) rehabilitation.
92508	group, 2 or more individuals	$24.30	**$23.61**	See also: Medicare Guidelines for Group Therapy and Modes of Service Delivery for Speech-Language Pathology
92511	Nasopharyngoscopy with endoscope (separate procedure)	$117.17	**$111.92**	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)	$64.24	**$62.43**	
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	$87.55	**$87.66**	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	$132.82	**$130.68**	
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	$111.18	**$108.68**	Don't bill 92522 in conjunction with 92523.

Code	Descriptor	2024 National Fee	2025 National Fee	Notes
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	$227.69	**$223.51**	Don't bill 92523 in conjunction with 92522.
92524	Behavioral and qualitative analysis of voice and resonance	$109.52	**$106.74**	This procedure doesn't include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding	$84.55	**$82.81**	See also: Answers to Your Feeding/Swallowing Coding Questions
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	$72.23	**$71.16**	
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	$123.83	**$120.98**	See also: Billing for AAC and Device Documentation
92608	each additional 30 minutes (List separately in addition to code for primary procedure)	$48.60	**$47.55**	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	$103.19	**$100.92**	See also: Billing for AAC and Device Documentation
92610	Evaluation of oral and pharyngeal swallowing function	$85.22	**$83.45**	See also: Answers to Your Feeding/Swallowing Coding Questions
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	$91.87	**$88.95**	92611 reflects the SLP's work during the study. Radiologists separately report 74230 (see Table 2) to report their participation in the study. See also: Answers to Your Feeding/Swallowing Coding Questions
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;	$198.39	**$193.43**	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	$35.95	**$35.26**	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	2024 National Fee	2025 National Fee	Notes
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	$149.13	**$145.88**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act.
92615	interpretation and report only	$32.29	**$31.38**	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;	$228.35	**$224.48**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act.
92617	interpretation and report only	$40.28	**$39.14**	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	$85.88	**$83.45**	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)	$20.31	**$19.73**	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	$95.87	**$93.80**	

Code	Descriptor	2024 National Fee	2025 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	$123.83	**$127.12**	
96113	each additional 30 minutes (List separately in addition to code for primary procedure)	$59.92	**$53.37**	
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	$102.19	**$96.63**	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	$22.30	**$21.67**	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)	$21.30	**$20.70**	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	$62.25	**$60.49**	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	2024 National Fee	2025 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	$32.62	**$32.02**	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	$52.93	**$52.08**	See 2024 CPT Code Changes
97551	each additional 15 minutes (List separately in addition to code for primary procedure)	$26.30	**$25.55**	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	$22.30	**$22.00**	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	$11.65	**$11.32**	See also: Use of Communication Technology-Based Services During COVID-19
98971	11-20 minutes	$20.64	**$21.35**	
98972	21 or more minutes	$30.62	**$32.35**	

Code	Descriptor	2024 National Fee	2025 National Fee	Notes
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment	$19.97	**$19.73**	See also: Use of Communication Technology-Based Services 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	**$43.02**	
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	**$43.02**	
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	**N/A**	See also: Speech-Language Pathology CPT and HCPCS Code Changes for 2023 and Use of Communication Technology-Based Services 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	$50.60	**$50.14**	See also: Use of Communication Technology-Based Services 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)	$39.95	**$39.14**	
G0451	Developmental testing, with interpretation and report, per standardized instrument form	$11.65	**$11.32**	This Medicare-specific HCPCS Level II code can be used in place of CPT 96110, which isn't paid by Medicare.
G0541	Caregiver training in direct care strategies and techniques to support care for patients with ongoing conditions or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes	N/A	**$52.08**	**New in 2025.** See 2025 HCPCS Code Changes.

Code	Descriptor	2024 National Fee	2025 National Fee	Notes
G0542	each additional 15 minutes (List separately in addition to code for primary service)	N/A	**$25.55**	This is an add-on code to report in conjunction with G0452 for each additional 15 minutes of training.
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers	N/A	**$22.00**	**New in 2025.** See 2025 HCPCS Code Changes.
G2250	Remote assessment of recorded video and/or images submitted by an established patient (eg, 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	**$11.97**	See also: Use of Communication Technology-Based Services During COVID-19
G2251	Brief communication technology-based service, eg, 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	**$13.91**	See also: Use of Communication Technology-Based Services 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 Codes

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

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

Code	Descriptor	2025 National Fee	Notes
31575	Laryngoscopy, flexible; diagnostic	**$123.89**	This procedure is for medical diagnosis by a physician.
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	**$108.36**	This is a radiology code.
74230	Swallowing function, with cineradiography/videoradiography	**$118.06**	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	**$106.10**	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	**$87.98**	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)	**$30.73**	*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	**$75.69**	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 nonpayable 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 nonpayable code. However, auditory (aural) rehabilitation is a covered Medicare benefit, so CMS instructs SLPs to use **92507** instead.

Code	Descriptor	2025 National Fee	Notes
96110	Developmental screening, with interpretation and report, per standardized instrument form	**$11.32**	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	**$28.79**	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	**$32.02**	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)	**$17.47**	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	**$34.61**	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	Brief communication technology-based service, eg virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	**$25.55**	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. 9). For geographically adjusted RVUs, go to Addendum E in the CMS CY 2025 PFS Final Rule Addenda [ZIP] files.

Code	Professional Work	Nonfacility Practice Expense	Malpractice	Nonfacility Total
31579	1.88	3.76	0.25	5.89
92507	1.30	0.99	0.03	2.32
92508	0.33	0.39	0.01	0.73
92511	0.61	2.81	0.04	3.46
92512	0.55	1.34	0.04	1.93
92520	0.75	1.93	0.03	2.71
92521	2.24	1.75	0.05	4.04
92522	1.92	1.38	0.06	3.36
92523	3.84	2.97	0.10	6.91
92524	1.92	1.33	0.05	3.30
92526	1.34	1.19	0.03	2.56
92597	1.26	0.90	0.04	2.20
92607	1.85	1.85	0.04	3.74
92608	0.70	0.75	0.02	1.47
92609	1.50	1.58	0.04	3.12
92610	1.30	1.24	0.04	2.58
92611	1.34	1.36	0.05	2.75
92612	1.27	4.66	0.05	5.98
92613	0.71	0.34	0.04	1.09
92614	1.27	3.18	0.06	4.51
92615	0.63	0.30	0.04	0.97
92616	1.88	4.96	0.10	6.94
92617	0.79	0.38	0.04	1.21
92626	1.40	1.14	0.04	2.58
92627	0.33	0.27	0.01	0.61
96105	1.75	1.09	0.06	2.90
96112	2.56	1.21	0.16	3.93
96113	1.16	0.45	0.04	1.65
96125	1.70	1.33	0.05	3.08
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	0.53	0.01	0.99
97550	1.00	0.58	0.03	1.61
97551	0.54	0.24	0.01	0.79

Code	Professional Work	Nonfacility Practice Expense	Malpractice	Nonfacility Total
97552	0.23	0.44	0.01	0.68
98970	0.25	0.09	0.01	0.35
98971	0.44	0.19	0.03	0.66
98972	0.69	0.28	0.03	1.00
98975	0.00	0.59	0.02	0.61
98976	0.00	1.32	0.01	1.33
98977	0.00	1.32	0.01	1.33
98980	0.62	0.89	0.04	1.55
98981	0.61	0.56	0.04	1.21
G0451	0.00	0.34	0.01	0.35
G0541	1.00	0.58	0.03	1.61
G0542	0.54	0.24	0.01	0.79
G0543	0.23	0.44	0.01	0.68
G2250	0.18	0.18	0.01	0.37
G2251	0.25	0.16	0.02	0.43

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