

2022

Medicare Fee Schedule for Audiologists



General Information

The American Speech-Language-Hearing Association (ASHA) developed this document to provide an analysis of the 2022 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

December 27, 2021

- Added information on Congressional action to mitigate the Medicare payment cuts. (p. 3-4)
- Updated the 2022 conversion factor. (p. 3)
- Updated national payment rates and relative value units in Tables 1-3. (p. 8)

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Overview

Outpatient audiology services provided under Part B of the Medicare program are paid under the Medicare Physician Fee Schedule (MPFS). Congress approves annual payment updates to the MPFS, which are frozen at 0.0% from 2020 through 2025 because of a provision 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 reevaluation of certain codes that are flagged as potentially misvalued services.

This document includes regulations and rates for implementation on January 1, 2022, for audiologists providing services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include new codes for remote therapeutic monitoring; audio-only virtual check-in services; telehealth services; 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 2022 Medicare Physician Fee Schedule (MPFS)

ASHA reviewed relevant sections of the [2022 MPFS final rule](#) and offers the following analysis of key issues for audiologists.

Payment Rates

(updated 12/27/21)

CMS did not finalize specific actions to mitigate the payment cuts set to return in 2022 for audiologists, speech-language pathologists (SLPs), and over 30 other Medicare provider groups. These cuts would have gone into effect in 2021 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 [prevented some of the payment cuts](#) and [mitigated other payment cuts](#) for the duration of 2021, the cuts were set to return in full in 2022.

However, continued advocacy resulted in provisions of the Protecting Medicare and Farmers from Sequester Cuts Act (P.L. 117-71) that [significantly reduced 2022 payment cuts by approximately 8%](#). As a result, ASHA estimates audiologists will now see an overall 2% decrease in 2022 payments.

ASHA remains fully committed to fighting any cuts to Medicare reimbursement. While far from ideal, S. 610 reduces near-term Medicare payment cuts—which could have been as high as 10% or more—allowing additional time for ASHA to continue working toward a long-term policy solution.

Learn more about [ASHA's ongoing efforts to stop the Medicare payment cuts](#) and **join the fight** to convince Congress to more fully address these cuts by urging support for the [Supporting Medicare Providers Act of 2021\(H.R. 6020/S. 3314\)](#).

Conversion Factor (CF)

CMS uses the CF to calculate MPFS payment rates. CMS initially established a calendar year (CY) 2022 CF of \$33.59, representing an almost 4% decrease from the \$34.89 CF for 2021, and an almost 7%

decrease from the 2020 CF, due in large part to the E/M code changes and the expiration of the 3.75% payment adjustment. Following Congressional intervention, the updated CY 2022 CF is now **\$34.61**, representing a 3% increase from the initial CF.

Payment Changes for Audiology Services

As a result of provisions of P.L. 117-71, audiologists will see the following adjustments on 2022 payments.

- A cut of 0.75% to the Medicare Part B conversion factor, which applies to every service *before* co-insurance, deductibles, and other payment adjustments applied at the claim level throughout 2022 (reduced from a 3.75% cut). **Table 1 (p. 8)** reflects payment rates with the 0.75% reduction.
- A separate, phased-in cut—known as sequestration—applies to all claims *after* co-insurance, deductibles, and other payment adjustments: Audiologists will experience no sequestration reductions in the first quarter of 2022, a 1% cut in the second quarter, and a 2% cut in the third and fourth quarters for a cumulative 1.25% cut over the year (reduced from a cumulative 6% cut).

Table 1 does not reflect the sequestration cuts, as these are made at the claim level. To see a quarterly estimate of 2022 payments for individual services after patient cost-sharing is applied, please contact reimbursement@asha.org to request ASHA's Medicare cuts calculator.

The incremental increase of the sequestration cuts over the course of 2022 is a mechanism to control federal spending, as the price tag for addressing the various cuts is significant. As a result, additional advocacy by ASHA and associated stakeholders is ongoing to more fully mitigate the cuts.

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 2% increase to the national payment rate while CPT code 92604 (cochlear implant reprogramming, age 7 years or older) will experience a 0% change. 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 2021 non-facility rates for comparison with 2022 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 2022 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].

CPT and HCPCS Code Updates

The final rule implements the following CPT and Healthcare Common Procedures Coding System (HCPCS) code changes in the 2022 MPFS. [ASHA's website](#) and [The ASHA Leader](#) provide additional details regarding the 2022 coding updates.

Deleted Codes

CPT codes **92599** (audiometric testing of groups), **92560** (Bekesy audiometry; screening), **92561** (Bekesy audiometry; diagnostic), and **92564** (short increment sensitivity index) will be deleted because changes in technology and clinical practice resulted in low utilization of these tests.

Audiologists should use CPT code **92700** (unlisted otorhinolaryngological service or procedure) to report these tests beginning in 2022.

New Remote Therapeutic Monitoring (RTM) Codes

New CPT codes **98975-98977**, **98980**, and **98981** will allow clinicians who cannot bill for E/M services to report remote monitoring of health conditions as well as adherence and response to treatment during an episode of care. In response to comments from ASHA and other stakeholders, CMS agreed that these services are important to beneficiaries and will allow certain nonphysician providers to bill the RTM codes, as written.

CMS did not provide specific guidance regarding audiology-related RTM services. In addition, CMS designated the new codes as "sometimes therapy" codes, meaning that they may only be billed outside of a therapy plan of care by a physician or certain other nonphysician practitioners, such as a physician assistant or nurse practitioner, when appropriate. Therefore, ASHA concludes that audiologists may not report these services under the MPFS due to limitations of the audiology diagnostic benefit. ASHA will continue to work with CMS to identify opportunities to allow audiologists to bill for RTM services that fit within the Medicare benefit.

Clinicians should contact non-Medicare payers regarding coverage and coding of RTM services, as individual payer policies will vary. Please see ASHA's website for a [full description of the new codes](#).

Extended Virtual Check-In Code

In 2021, CMS established a new HCPCS code, **G2252**, for extended virtual check-in services using any form of synchronous communications technology—including audio-only—to help providers stay connected with Medicare beneficiaries who may not have access to audio-visual technology. Unfortunately, CMS excluded providers who cannot report E/M services under the MPFS, including audiologists.

Despite ASHA's request to allow audiologists to report this important service, CMS has opted not to expand the use of G2252 in 2022. CMS did acknowledge ASHA's comments and indicated they will consider them in future rulemaking. ASHA will continue to urge CMS to allow audiologists to bill G2252 and other communication technology-based services (CTBS), such as e-visits. Clinicians should contact non-Medicare payers regarding coverage of virtual check-ins and other CTB services, as individual payer policies will vary. See ASHA's website for more information on [CTBS codes](#).

Medicare Telehealth Services

Although CMS addressed telehealth services in the final rule, there are no telehealth changes for audiologists in 2022. CMS lacks the statutory authority to maintain the [telehealth flexibilities](#) allowed

during the federal public health emergency (PHE); therefore, audiologists will no longer receive Medicare reimbursement for telehealth services when the [federal PHE expires](#). The U.S. Secretary of Health and Human Services has extended the PHE numerous times since January 2020 and may continue to extend it in 2022. Please monitor ASHA's [advocacy news](#) for updates on significant changes to the federally declared PHE.

ASHA remains committed to securing Congressional authority for audiologists to receive reimbursement for services provided via telehealth for an extended period beyond the federal PHE and will continue advocating for a permanent legislative solution. Audiologists can [take action](#) by asking your members of Congress to improve Medicare beneficiaries' access to audiology 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. Audiologists first became eligible for MIPS in 2019 and will continue to participate in the program in 2022. 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 2022, which will be used to adjust their payments in 2024.

Since CMS has set exclusions and low-volume thresholds, a large majority of audiologists will be excluded from mandatory MIPS participation for 2022. 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 eligible for mandatory reporting, CMS will apply a payment incentive or penalty to 2024 Medicare payments for performance on the quality and improvement activities (IAs) performance categories in 2022. 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 2022, audiologists have eight potentially applicable measures; but CMS is removing the option to report *Measure 182: Functional Outcomes Assessment* via claims and will only allow electronic reporting (e.g., reporting via an electronic health record). Audiologists maintain the flexibility to select among seven options for claims-based reporting, as only a minimum of six measures must be reported. ASHA's website provides [additional details and ongoing updates regarding MIPS](#).

- 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
Updated to reflect function in terms of hearing; no longer eligible for claims-based reporting
- 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

For the IA performance category, audiologists must score a minimum of 40 points and attest to their completion via the [CMS QPP website](#). See Appendix 2 of the final rule for a full list of IAs.

Advanced Alternative Payment Models (APMs)

APMs, a key initiative within the QPP, [incentivize providers who shift towards quality and value](#). Audiologists may participate in the [Advanced APM](#) option in 2022. Those who successfully participate will receive a 5% lump-sum incentive payment on their Part B services in 2024. Pursuant to the Consolidated Appropriations Act passed last year, CMS is freezing APM thresholds at the 2020 levels. For performance year 2022, the Medicare-Only payment threshold is 50% and the patient count threshold is 35%. In other words, at least 50% of your Medicare Part B payments or at least 35% of your Medicare patients must be seen through an Advanced APM entity. Under the All-Payer Combination Option, you must first meet certain threshold percentages under the Medicare Option, which is 25% for the payment amount method or 20% under the patient count method.

This payment and patient count threshold freeze will help more providers—like audiologists—in Advanced APMs qualify for the 5% bonus. These thresholds are designed to measure whether the provider is actively taking steps to increase their participation in value-based care arrangements.

Determination of the Advanced APM 5% bonus takes place at the facility/APM entity level (Tax Identification Number or TIN) or at the individual eligible clinical level.

2022 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 2022 CF (**\$34.61**). The table also includes 2021 non-facility rates for comparison with 2022 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	2021 National Fee <i>Non-Facility</i>	2022 National Fee		Notes
				<i>Non-Facility</i>	<i>Facility</i>	
92517		Vestibular evoked myogenic potential testing, with interpretation and report; cervical (cVEMP)	\$85.84	\$69.90	\$42.22	
92518		ocular (oVEMP)	\$79.91	\$65.75	\$42.22	
92519		cervical (cVEMP) and ocular (oVEMP)	\$133.64	\$108.66	\$63.33	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)	\$41.87	\$41.87	N/A	
92537	TC	bithermal...	\$10.47	\$10.38	N/A	
92537	26	bithermal...	\$31.40	\$31.49	\$31.49	
92538		monothermal (ie, one irrigation in each ear for a total of two irrigations)	\$22.33	\$23.19	N/A	

Code	Mod	Descriptor	2021 National Fee <i>Non-Facility</i>	2022 National Fee		Notes
				<i>Non-Facility</i>	<i>Facility</i>	
92538	TC	monothermal...	\$6.63	\$6.92	N/A	
92538	26	monothermal...	\$15.70	\$16.26	\$16.26	
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	\$110.26	\$113.16	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...	\$32.45	\$34.26	N/A	
92540	26	Basic vestibular evaluation...	\$77.81	\$78.90	\$78.90	
92541		Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	\$25.12	\$25.95	N/A	
92541	TC	Spontaneous nystagmus test...	\$4.19	\$4.84	N/A	
92541	26	Spontaneous nystagmus test...	\$20.94	\$21.11	\$21.11	
92542		Positional nystagmus test, minimum of 4 positions, with recording	\$29.31	\$29.76	N/A	
92542	TC	Positional nystagmus test...	\$4.19	\$4.50	N/A	
92542	26	Positional nystagmus test...	\$25.12	\$25.26	\$25.26	
92544		Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	\$17.80	\$18.34	N/A	
92544	TC	Optokinetic nystagmus test...	\$3.49	\$3.81	N/A	
92544	26	Optokinetic nystagmus test...	\$14.31	\$14.53	\$14.53	
92545		Oscillating tracking test, with recording	\$16.40	\$17.30	N/A	
92545	TC	Oscillating tracking test...	\$3.14	\$3.81	N/A	
92545	26	Oscillating tracking test...	\$13.26	\$13.50	\$13.50	
92546		Sinusoidal vertical axis rotational testing	\$120.38	\$128.04	N/A	

Code	Mod	Descriptor	2021 National Fee <i>Non-Facility</i>	2022 National Fee		Notes
				<i>Non-Facility</i>	<i>Facility</i>	
92546	TC	Sinusoidal vertical axis rotational testing	\$105.73	\$112.82	N/A	
92546	26	Sinusoidal vertical axis rotational testing	\$14.66	\$15.23	\$15.23	
92547		Use of vertical electrodes (List separately in addition to code for primary procedure)	\$10.12	\$10.73	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)	\$49.55	\$49.83	N/A	
92548	TC	CDP-SOT	\$15.35	\$15.23	N/A	
92548	26	CDP-SOT	\$34.20	\$34.61	\$34.61	
92549		with motor control test (MCT) and adaptation test (ADT)	\$63.16	\$65.06	N/A	This is a stand-alone code to report when performing all three CDP tests (SOT, MCT, and ADT). Don't bill in conjunction with 92548.
92549	TC	with MCT and ADT	\$18.84	\$20.07	N/A	
92549	26	with MCT and ADT	\$44.31	\$44.99	\$44.99	
92550		Tympanometry and reflex threshold measurements	\$21.98	\$22.84	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	\$32.45	\$34.26	N/A	
92553		air and bone	\$39.78	\$41.53	N/A	
92555		Speech audiometry threshold;	\$24.77	\$25.95	N/A	
92556		with speech recognition	\$39.43	\$40.84	N/A	

Code	Mod	Descriptor	2021 National Fee <i>Non-Facility</i>	2022 National Fee		Notes
				<i>Non-Facility</i>	<i>Facility</i>	
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	\$37.68	\$38.41	\$32.88	Don't report 92557 if you haven't completed all required components (pure tone air and bone conduction, speech reception thresholds, and speech recognition testing). Instead, bill for the individual components of testing using 92552, 92553, 92555, or 92556. Don't report 92557 in conjunction with 92552, 92553, 92555, or 92556.
92561		Bekesy audiometry; diagnostic	\$39.43	\$0.00	\$0.00	Deleted in 2022. Report 92700 (unlisted procedure) for Bekesy testing. See also: Audiology CPT and HCPCS Code Changes for 2022
92562		Loudness balance test, alternate binaural or monaural	\$46.76	\$47.06	N/A	
92563		Tone decay test	\$31.40	\$32.53	N/A	
92564		Short increment sensitivity index (SISI)	\$23.73	\$0.00	\$0.00	Deleted in 2022. Report 92700 (unlisted procedure) for SISI testing. See also: Audiology CPT and HCPCS Code Changes for 2022
92565		Stenger test, pure tone	\$17.45	\$19.38	N/A	
92567		Tympanometry (impedance testing)	\$16.40	\$16.96	\$10.73	
92568		Acoustic reflex testing, threshold	\$15.00	\$15.92	\$15.57	
92570		Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	\$32.45	\$33.57	\$30.11	Don't 92570 if you haven't completed all three components of testing, as listed in the code descriptor. Instead, bill for the individual tests, 92567 or 92568. Don't report 92570 in conjunction with 92567 or 92568.
92571		Filtered speech test	\$27.91	\$29.07	N/A	
92572		Staggered spondaic word test	\$35.94	\$41.87	N/A	
92575		Sensorineural acuity level test	\$68.74	\$71.63	N/A	

Code	Mod	Descriptor	2021 National Fee <i>Non-Facility</i>	2022 National Fee		Notes
				<i>Non-Facility</i>	<i>Facility</i>	
92576		Synthetic sentence identification test	\$38.03	\$38.76	N/A	
92577		Stenger test, speech	\$15.00	\$19.03	N/A	
92579		Visual reinforcement audiometry (VRA)	\$46.41	\$47.06	\$38.41	
92582		Conditioning play audiometry	\$75.72	\$78.90	N/A	
92583		Select picture audiometry	\$50.94	\$51.56	N/A	
92584		Electrocochleography	\$119.68	\$117.66	N/A	
92587		Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3–6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	\$21.98	\$22.49	N/A	See also: CPT Coding for Otoacoustic Emissions
92587	TC	Distortion product evoked otoacoustic emissions...limited	\$3.84	\$4.15	N/A	
92587	26	Distortion product evoked otoacoustic emissions...limited	\$18.14	\$18.34	\$18.34	
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	\$33.85	\$34.61	N/A	See also: CPT Coding for Otoacoustic Emissions
92588	TC	Distortion product evoked otoacoustic emissions...comprehensive	\$5.23	\$5.54	N/A	
92588	26	Distortion product evoked otoacoustic emissions...comprehensive	\$28.61	\$29.07	\$29.07	
92596		Ear protector attenuation measurements	\$68.04	\$69.90	N/A	
92601		Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	\$167.14	\$166.80	\$125.62	
92602		subsequent reprogramming	\$106.42	\$105.55	\$70.94	

Code	Mod	Descriptor	2021 National Fee <i>Non-Facility</i>	2022 National Fee		Notes
				<i>Non-Facility</i>	<i>Facility</i>	
92603		Diagnostic analysis of cochlear implant, age 7 years or older; with programming	\$155.27	\$156.07	\$122.16	
92604		subsequent reprogramming	\$94.21	\$94.13	\$67.83	
92620		Evaluation of central auditory function, with report; initial 60 minutes	\$92.47	\$93.09	\$81.67	
92621		each additional 15 minutes (List separately in addition to code for primary procedure)	\$22.68	\$22.49	\$19.03	This is an add-on code to report in conjunction with 92620 for each additional 15 minutes of evaluation.
92625		Assessment of tinnitus (includes pitch, loudness matching, and masking)	\$69.09	\$69.90	\$62.29	
92626		Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); first hour	\$89.33	\$89.98	\$75.79	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)	\$21.28	\$21.11	\$18.00	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	\$113.75	\$113.51	\$96.21	

Code	Mod	Descriptor	2021 National Fee <i>Non-Facility</i>	2022 National Fee		Notes
				<i>Non-Facility</i>	<i>Facility</i>	
92651		Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	\$89.68	\$90.32	N/A	<p>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.</p> <p>Don't report 92651 in conjunction with 92652 or 92653.</p> <p>See also: Audiology CPT and HCPCS Code Changes for 2021</p>
92652		for threshold estimation at multiple frequencies, with interpretation and report	\$116.54	\$118.35	N/A	<p>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.</p> <p>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.</p> <p>See also: Audiology CPT and HCPCS Code Changes for 2021</p>

Code	Mod	Descriptor	2021 National Fee <i>Non-Facility</i>	2022 National Fee		Notes
				<i>Non-Facility</i>	<i>Facility</i>	
92653		neurodiagnostic, with interpretation and report	\$85.84	\$87.90	N/A	<p>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.</p> <p>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.</p> <p>See also: Audiology CPT and HCPCS Code Changes for 2021</p>
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 hearing and balance diagnostic services. Although they are within the scope of practice of an ASHA-certified audiologist, Medicare does not recognize screenings, treatment, hearing aid, and electrophysiological services outside the hearing and balance systems when performed by an audiologist. Services in this table that are included as a Medicare benefit may be billed to Medicare when performed under the supervision of a physician and billed under the physician’s National Provider Identifier (NPI) number (“[incident to](#)”). Services listed in Table 1 (p.8) that are part of the audiology benefit must be billed under the audiologist’s NPI and may *not* be billed “incident to” a physician (i.e., under the physician’s NPI).

Code	Mod	Descriptor	2022 National Fee		Notes
			Non-Facility	Facility	
69209		Removal impacted cerumen using irrigation/lavage, unilateral	\$15.57	N/A	Not covered under the audiology benefit.
69210		Removal impacted cerumen requiring instrumentation, unilateral (for bilateral procedure, report 69210)	\$48.45	\$33.57	Not covered under the audiology benefit.
92516		Facial nerve function studies (eg, electroneuronography)	\$70.94	\$23.19	Covered under physician supervision.
92531		Spontaneous nystagmus, including gaze	\$0.00	\$0.00	Medicare doesn’t cover vestibular tests <i>without</i> recording. See 92537-92548 in Table 1 for vestibular tests with recording.
92532		Positional nystagmus test	\$0.00	\$0.00	
92533		Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests)	\$0.00	\$0.00	
92534		Optokinetic nystagmus test	\$0.00	\$0.00	
92551		Screening test, pure tone, air only	\$11.77	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	\$9.69	\$8.65	Medicare doesn’t cover screenings, but rates are published as reference, when available.
92559		Audiometric testing of groups	\$0.00	\$0.00	Deleted in 2022. Report 92700 (unlisted procedure) for group testing. However, group testing isn’t paid under the MPFS. See also: Audiology CPT and HCPCS Code Changes for 2022

Code	Mod	Descriptor	2022 National Fee		Notes
			Non-Facility	Facility	
92560		Bekesy audiometry; screening	\$0.00	\$0.00	Deleted in 2022. Report 92700 (unlisted procedure) for Bekesy screening. However, Medicare doesn't cover screenings. See also: Audiology CPT and HCPCS Code Changes for 2022
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	
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	\$29.42	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	\$94.13	N/A	Covered under physician supervision.
95907	TC	1–2 studies	\$40.49	N/A	
95907	26	1–2 studies	\$53.64	\$53.64	
95908		Nerve conduction studies; 3–4 studies	\$117.32	N/A	Covered under physician supervision.
95908	TC	3–4 studies	\$50.18	N/A	
95908	26	3–4 studies	\$67.14	\$67.14	
95909		Nerve conduction studies; 5–6 studies	\$140.85	N/A	Covered under physician supervision.
95909	TC	5–6 studies	\$60.21	N/A	
95909	26	5–6 studies	\$80.63	\$80.63	
95910		Nerve conduction studies; 7–8 studies	\$184.10	N/A	Covered under physician supervision.
95910	TC	7–8 studies	\$76.48	N/A	

Code	Mod	Descriptor	2022 National Fee		Notes
			Non-Facility	Facility	
95910	26	7–8 studies	\$107.63	\$107.63	
95911		Nerve conduction studies; 9–10 studies	\$221.48	N/A	Covered under physician supervision.
95911	TC	9–10 studies	\$87.90	N/A	
95911	26	9–10 studies	\$133.58	\$133.58	
95912		Nerve conduction studies; 11–12 studies	\$257.82	N/A	Covered under physician supervision.
95912	TC	11–12 studies	\$98.63	N/A	
95912	26	11–12 studies	\$159.19	\$159.19	
95913		Nerve conduction studies; 13 or more studies	\$298.31	N/A	Covered under physician supervision.
95913	TC	13 or more studies	\$109.36	N/A	
95913	26	13 or more studies	\$188.95	\$188.95	
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	\$189.99	N/A	Covered under physician supervision.
95925	TC	in upper limbs	\$160.92	N/A	
95925	26	in upper limbs	\$29.07	\$29.07	
95926		in lower limbs	\$164.38	N/A	Covered under physician supervision.
95926	TC	in lower limbs	\$136.35	N/A	
95926	26	in lower limbs	\$28.03	\$28.03	
95938*		in upper and lower limbs	\$373.05	N/A	*Out of numerical order. Covered under physician supervision.
95938	TC	in upper and lower limbs	\$327.03	N/A	
95938	26	in upper and lower limbs	\$46.03	\$46.03	
95927		in the trunk or head	\$154.69	N/A	Covered under physician supervision.
95927	TC	in the trunk or head	\$127.70	N/A	
95927	26	in the trunk or head	\$26.99	\$26.99	
95930		Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	\$67.14	N/A	Covered under physician supervision.
95930	TC	checkerboard or flash	\$48.45	N/A	
95930	26	checkerboard or flash	\$18.69	\$18.69	

Code	Mod	Descriptor	2022 National Fee		Notes
			Non-Facility	Facility	
95937		Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	\$110.39	N/A	Covered under physician supervision.
95937	TC	Neuromuscular junction testing...	\$75.44	N/A	
95937	26	Neuromuscular junction testing...	\$34.95	\$34.95	
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	\$32.88	Covered under physician supervision.
95941		Continuous neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	\$0.00	\$0.00	Not recognized by Medicare. See G0453 below.
95992		Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day	\$44.30	\$37.03	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	\$11.77	\$11.77	Not covered under the audiology benefit. See also: Audiology CPT and HCPCS Code Changes for 2021 and Use of CTBS Codes During COVID-19
98971		11-20 minutes	\$20.76	\$20.42	See note for 98970.
98972		21 or more minutes	\$32.18	\$31.84	
98975		Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	\$19.38	N/A	New in 2022. Not covered under the audiology benefit. See also: Audiology CPT and HCPCS Code Changes for 2022 and 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	\$55.72	N/A	See also: Audiology CPT and HCPCS Code Changes for 2022 and Use of CTBS Codes During COVID-19

Code	Mod	Descriptor	2022 National Fee		Notes
			Non-Facility	Facility	
98977		device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	\$55.72	N/A	New in 2022. Not covered under the audiology benefit. See also: Audiology CPT and HCPCS Code Changes for 2022 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	\$50.18	\$31.49	
98981		each additional 20 minutes (listed separately in addition to code for primary procedure)	\$40.84	\$31.49	
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	\$32.88	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	\$12.11	\$9.34	Not covered under the audiology benefit.
G2251		Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	\$14.53	\$12.80	See also: Audiology CPT and HCPCS Code Changes for 2021 and 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 2022 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	0.05	1.17	2.02	0.37	1.22
92518		0.80	0.05	1.05	1.90	0.37	1.22
92519		1.20	0.08	1.86	3.14	0.55	1.83
92537		0.60	0.02	0.59	1.21	N/A	N/A
92537	TC	0.00	0.01	0.29	0.30	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	0.05	1.72	3.27	N/A	N/A
92540	TC	0.00	0.01	0.98	0.99	N/A	N/A
92540	26	1.50	0.04	0.74	2.28	0.74	2.28
92541		0.40	0.02	0.33	0.75	N/A	N/A
92541	TC	0.00	0.01	0.13	0.14	N/A	N/A
92541	26	0.40	0.01	0.20	0.61	0.20	0.61
92542		0.48	0.02	0.36	0.86	N/A	N/A
92542	TC	0.00	0.01	0.12	0.13	N/A	N/A
92542	26	0.48	0.01	0.24	0.73	0.24	0.73
92544		0.27	0.02	0.24	0.53	N/A	N/A
92544	TC	0.00	0.01	0.10	0.11	N/A	N/A
92544	26	0.27	0.01	0.14	0.42	0.14	0.42
92545		0.25	0.02	0.23	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	3.38	3.70	N/A	N/A
92546	TC	0.00	0.02	3.24	3.26	N/A	N/A
92546	26	0.29	0.01	0.14	0.44	0.14	0.44
92547		0.00	0.00	0.31	0.31	N/A	N/A
92548		0.67	0.03	0.74	1.44	N/A	N/A
92548	TC	0.00	0.01	0.43	0.44	N/A	N/A
92548	26	0.67	0.02	0.31	1.00	0.31	1.00
92549		0.87	0.02	0.99	1.88	N/A	N/A
92549	TC	0.00	0.01	0.57	0.58	N/A	N/A
92549	26	0.87	0.01	0.42	1.30	0.42	1.30
92550		0.35	0.02	0.29	0.66	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	0.98	0.99	N/A	N/A
92553		0.00	0.01	1.19	1.20	N/A	N/A
92555		0.00	0.01	0.74	0.75	N/A	N/A
92556		0.00	0.01	1.17	1.18	N/A	N/A
92557		0.60	0.04	0.47	1.11	0.31	0.95
92562		0.00	0.01	1.35	1.36	N/A	N/A
92563		0.00	0.01	0.93	0.94	N/A	N/A
92565		0.00	0.01	0.55	0.56	N/A	N/A
92567		0.20	0.01	0.28	0.49	0.10	0.31
92568		0.29	0.02	0.15	0.46	0.14	0.45
92570		0.55	0.04	0.38	0.97	0.28	0.87
92571		0.00	0.01	0.83	0.84	N/A	N/A
92572		0.00	0.01	1.20	1.21	N/A	N/A
92575		0.00	0.04	2.03	2.07	N/A	N/A
92576		0.00	0.01	1.11	1.12	N/A	N/A
92577		0.00	0.01	0.54	0.55	N/A	N/A
92579		0.70	0.04	0.62	1.36	0.37	1.11
92582		0.00	0.02	2.26	2.28	N/A	N/A
92583		0.00	0.01	1.48	1.49	N/A	N/A
92584		1.00	0.05	2.35	3.40	N/A	N/A
92587		0.35	0.02	0.28	0.65	N/A	N/A
92587	TC	0.00	0.01	0.11	0.12	N/A	N/A
92587	26	0.35	0.01	0.17	0.53	0.17	0.53
92588		0.55	0.02	0.43	1.00	N/A	N/A
92588	TC	0.00	0.01	0.15	0.16	N/A	N/A
92588	26	0.55	0.01	0.28	0.84	0.28	0.84
92596		0.00	0.01	2.01	2.02	N/A	N/A
92601		2.30	0.09	2.43	4.82	1.24	3.63
92602		1.30	0.05	1.70	3.05	0.70	2.05
92603		2.25	0.09	2.17	4.51	1.19	3.53
92604		1.25	0.05	1.42	2.72	0.66	1.96
92620		1.50	0.08	1.11	2.69	0.78	2.36
92621		0.35	0.01	0.29	0.65	0.19	0.55
92625		1.15	0.05	0.82	2.02	0.60	1.80
92626		1.40	0.05	1.15	2.60	0.74	2.19
92627		0.33	0.01	0.27	0.61	0.18	0.52
92640		1.76	0.07	1.45	3.28	0.95	2.78
92651		1.00	0.05	1.56	2.61	N/A	N/A
92652		1.50	0.09	1.83	3.42	N/A	N/A
92653		1.05	0.07	1.42	2.54	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.

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