2026

Medicare Fee Schedule for Audiologists

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General Information

The American Speech-Language-Hearing Association (ASHA) developed this document to provide an analysis of the 2026 Medicare Physician Fee Schedule (MPFS), including explanation of 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, instructions for calculating Medicare payment, and audiology-specific payment and coding rules. If you have any questions, contact reimbursement@asha.org.

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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). This document summarizes regulations and rates for **implementation on January 1, 2026**, 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; alternative payment models (APMs); and national payment rates for audiology-related services.

The 2026 MPFS includes modest payment updates but continues to place downward pressure on audiology reimbursement. Although Congress approved a one-time 2.5% payment increase for 2026, these gains may be offset by new Centers for Medicare & Medicaid Services (CMS) policies and mandatory federal budget reductions, resulting in potential overall cuts of approximately 3% without additional legislative intervention.

In addition, CMS finalized permanent telehealth coverage for audiology codes—though congressional action has only extended coverage for audiologists through January 30, 2026—and maintained the limited direct-access policy allowing certain diagnostic services without a physician order. Most audiologists remain exempt from Merit-based Incentive Payment System (MIPS) reporting and have limited ability to participate in Advanced Alternative Payment Models (APMs), though participation opportunities continue. ASHA continues to advocate for congressional action to stabilize payment, extend telehealth authority, and expand the Medicare audiology benefit.

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 2026 Medicare Physician Fee Schedule (MPFS)

ASHA reviewed relevant sections of the 2026 MPFS final rule and provides the following analysis of key issues for audiologists.

Payment Rates

Congress establishes annual payment updates to the MPFS, which were frozen at 0.0% from 2020 through 2025 because of a provision in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Beginning in 2026, MACRA put in place a variable annual update dependent on participation in Advanced Alternative Payment Models (APMs). Those clinicians participating in APMs will receive an annual update of 0.75%. All other clinicians are eligible for a 0.25% annual update. The One Big Beautiful Bill Act (OBBBA) also provided a one-time positive payment update of 2.5% for 2026. Additional payment adjustments—based on legislative and regulatory actions, or participation in the MIPS or APMs—may also apply.

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

Significant payment cuts to all services provided under the MPFS will continue in 2026. These cuts have gone into effect each year since 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 resulted in legislation that mitigated the cuts each year—including the 2.5% update in 2026—audiologists will continue to face significant cuts year-over-year without additional intervention from Congress.

ASHA continues working with allied stakeholders to convince Congress to address the cuts with an additional positive adjustment for 2026 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 approximately 3%. ASHA members should prepare for a reduction effective January 1, 2026. Although Congress has partially 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 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. Beginning 2026, there will be two separate CFs:

1. **$33.57** for clinicians who **participate** in a qualified APM, representing a 3.8% increase from the 2025 CF.

2. **$33.40** for clinicians who **do not participate** in a qualified APM, representing a 3.3% increase from the 2025 CF.

Most audiologists do not participate in a qualifying APM and will use the $33.40 CF to calculate payment rates. These CFs reflect the combined increases mandated in MACRA and OBBBA (explained in more detail above) but fail to account for reductions that will be applied due to a variety of policy changes such as the efficiency adjustment imposed by CMS and elimination of the geographic practice cost index (GPCI) floor, which will reduce payment to specific localities beginning January 31, 2026. In some instances, these reductions eliminate and further reduce the legislative increases provided by Congress.

Payment Changes for Audiology Services

CMS provides a regulatory impact analysis (RIA), which estimates cumulative payment changes for providers *in addition* to the positive adjustments to the CF. For 2026, it's estimated that most individual audiologists will experience between a negative 1% to a positive 1% shift in payment in 2026 in *addition* to the adjustment to the CF.

However, Medicare providers face other Medicare cuts, including sequestration (2% reduction) and GPCI-related payment adjustments (varies by geographic locality) that require congressional intervention in early 2026. As a result, the cumulative impact of cuts audiologists face could reach 3% when these legislative reductions are added to the finalized MPFS payment cuts, such as the efficiency adjustment. Congress has consistently acted by passing legislation that significantly reduced some of the cuts over the past few years, including in 2025. 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 92576 (synthetic sentence identification test) will see a 4% decrease to the national payment rate while CPT code 92552 (pure tone audiometry [threshold]; air only) will experience a 4% 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. 10) for a summary of the various factors impacting 2026 MPFS payments. **See Table 2 (p. 12)** for a listing of audiology procedures and corresponding national payment rates. The table also includes 2025 non-facility rates for comparison with the updated 2026 rates to help audiologists estimate

the impact of the payment adjustments. 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 4 (p. 28)** for a detailed chart of final 2026 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 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].

Practice Expense (PE) RVU

Historically, CMS has maintained separate PE values for services provided in non-facility settings (such as private offices) and facility settings (such as skilled nursing facilities). Beginning in CY 2026, CMS will further increase the PE value for non-facility settings and reduce the PE value for facility settings across all CPT codes paid under the MPFS.

According to CMS, this revised approach better reflects the higher costs of providing services in non-facility settings and the efficiencies and economies of scale that facility settings can achieve. As part of this change, CMS will reduce the portion of facility PE RVUs allocated based on work RVUs to half the amount applied to non-facility PE RVUs.

In practical terms, specialties that deliver most of their services in facility settings will experience a decrease in PE RVUs, while those practicing primarily in non-facility settings will see a corresponding increase. For audiologists, the impact will vary by site of service. Because most audiologists provide care either in hospital outpatient departments—which are reimbursed under a different payment system—or in outpatient clinic or office settings, this policy is expected to have an overall positive impact on audiology payments under the MPFS. However, audiology services furnished in other facility-based settings, such as skilled nursing facilities, will experience reductions in payment. Specifically, CMS estimates that facility-based audiology services will see a cumulative 14% reduction. It is important to note that facility-based audiology services only comprise 4% of total allowed audiology charges under the MPFS.

Efficiency Adjustment

Despite extensive advocacy by ASHA and other stakeholders, CMS finalized a 2.5% "efficiency adjustment" that will reduce the work RVUs and intraservice time for certain CPT codes beginning in 2026. CMS adopted this policy because it believes that efficiency gains achieved over time are not adequately captured in the AMA's CPT code valuation process. The 2.5% reduction is based on cumulative productivity data from a five-year lookback period (CY 2021–2025) and may be reapplied every three years using the same methodology.

CMS is applying the efficiency adjustment primarily to non-time-based codes that describe procedures, radiologic services, and diagnostic tests. The agency contends that clinicians become more efficient in providing these types of services as they gain experience and as technology advances, leading to reduced time and effort required to perform them. As a result, some CPT codes used by audiologists will be affected by this reduction.

However, it is important to note that services in which the provider's time is the primary resource, as well as services included on the approved telehealth list, will not be subject to the efficiency adjustment. For example, CPT 92557 (comprehensive audiometry) is specifically exempt. In addition, new CPT codes introduced in any given year will be excluded from the efficiency adjustment for that calendar year.

See the CMS website [ZIP] for a full list of codes subject to the efficiency adjustment.

The table below illustrates the impact of the efficiency adjustment (EA) and PE changes on non-facility payments.

CPT code	Code Description	Total Time	Total Time After EA	Work RVU	Work RVU After EA	Rate with 2026 CF	Rate After EA & PE Changes
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	32 min	31.5 min	0.80	0.78	$75.47	$73.48

Malpractice (MP) RVUs and Geographic Practice Cost Indices (GPCIs)

CMS updates both MP RVUs and GPCIs every three years to ensure that payments remain aligned with current cost and risk data. The next update will take effect in CY 2026 and will impact payment rates for audiology services.

MP RVUs represent the portion of a CPT code's total RVU that accounts for professional liability insurance costs associated with a service. These values are based on the relative risk of malpractice claims across different medical specialties. While most MP values for audiology services did not change, CMS has finalized additional reductions to MP values for certain audiologic codes and did not provide any increases to MP values.

GPCIs adjust Medicare payments to reflect differences in the cost of care across various regions of the country. There are three separate GPCIs corresponding to the three RVU components:

- **Work GPCI**, which adjusts for geographic differences in clinical labor costs;
- **Practice Expense GPCI**, which accounts for regional variation in overhead costs such as rent, staff wages, and supplies; and
- **Malpractice GPCI**, which reflects differences in malpractice insurance premiums among geographic areas.

A nationwide 1.0 floor for the work GPCI was temporarily extended through January 30, 2026. Congress will need to once again extend the floor or make it permanent. Otherwise, geographic localities previously benefiting from it may see reductions in work GPCI-related payments in CY 2026. Visit ASHA's webpage on calculating Medicare fee schedule rates for information on how to access fees based on locality.

See Table 1 (p. 10) for a summary of the various factors impacting 2026 MPFS payments.

CPT Code Updates

The final rule announces the following CPT code changes in the 2026 MPFS. ASHA's website provides more information on 2026 coding updates.

Hearing Device Services

Effective January 1, 2026, CMS announced 12 new hearing device services codes replacing the long-standing CPT code set for hearing aid services. These new codes are a direct result of ASHA engagement with the AMA code development process in coordination with the American Academy of Audiology. While these codes will not be covered by Medicare due to a statutory prohibition on Medicare coverage of hearing aids and related services, commercial payers and state Medicaid programs may cover them. ASHA is working with major payers to encourage adoption of the new codes and provides a template letter audiologists can use to inform their payers regarding the new codes. Detailed information and useful tools related to the new code set, including a webinar, can be found on the ASHA website.

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 for 2026. 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. Data for the first year of the program will be available in 2025. This will allow ASHA to gain a better understanding of its use and utility as we seek to improve the policy. 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

After extensive ASHA advocacy, CMS finalized a policy that the CPT codes used by audiologists will remain permanently included on the list of covered Medicare telehealth services. This means all audiology services that have been covered via telehealth since 2020 will continue to be covered on a permanent basis. In addition, Congress included another short-term extension of Medicare telehealth coverage for nonphysician clinicians—including audiologists—through January 30, 2026. 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.

Codes for Auditory Osseointegrated Device (AOD) Services Added to Telehealth List

In response to ASHA's request, CMS has added the following CPT codes to the Medicare Telehealth Services List, beginning CY 2026:

- **92622**, Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
- **92623**, Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes

These additions represent an important step toward expanding telehealth access for individuals who rely on AODs.

Telehealth Billing Changes

CMS provided clarification in the final rule that clinicians can "suppress" their street address details when providing services from their home via telehealth (instead of their enrolled practice location) to protect their privacy and security in these instances. See the CMS website for more information.

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 2026. If an audiologist meets the criteria for a MIPS eligible clinician (EC), they will need to report data associated with quality measures, promoting interoperability, and improvement activities in 2026, which will be used to adjust their payments in 2028.

Because CMS has set exclusions and low-volume thresholds, a large majority of audiologists will continue to be excluded from mandatory MIPS participation for 2026. 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:

- Have $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 2028 Medicare payments for performance on the quality, promoting interoperability, and improvement activities (IAs) performance categories in 2026. 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. The MIPS performance threshold to avoid a penalty for the 2026 performance year (affecting 2028 payments) remains at 75 points. 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 2026, audiologists have 10 potentially applicable measures to choose from after CMS eliminated two measures associated with social determinants of health (SDOH). This provides audiologists with the flexibility to select six measures from the 10 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 317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Despite ASHA's opposition, CMS removed the following quality measure related to SDOH for the 2026 performance (impacting 2028 payment adjustments):

- Measure 487: Screening for Social Drivers of Health: Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
- 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): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least one of their HRSNs within 60 days after screening CMS eliminated two measures associated with social determinants of health.

For the IA performance category, audiologists must complete two activities and attest to their completion via the CMS QPP website. The "Achieving Health Equity" subcategory would be retired and replaced with a new subcategory: "Advancing Health and Wellness."

Audiologists participating in MIPS must also report measures, or seek exemptions from specific required measures, that demonstrate interoperable use of approved electronic health records. More information on this category can be found on the ASHA website.

The survey modes for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey are being expanded from a mail-phone administration protocol to a web-mail-phone administration protocol beginning with performance year 2027. CAHPS for MIPS Survey is an optional quality measure related to patients' experience of care that groups and virtual groups participating in MIPS can elect to administer. See the CMS website for more information.

Advanced Alternative Payment Models (APMs)

Only a small percentage of audiologists participate in the second track of the QPP, 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. Audiologists working for organizations participating in APMs can help their organizations earn incentive payments by engaging in quality improvement efforts.

Again, CMS finalized an update to the APM Performance Pathway (APP) Plus Quality Measure Set by removing Measure 487: Screening for Social Drivers of Health, a measure associated with social determinants of health (SDOH) and Measure 498: Connection to Community Service Provider for health-related social needs (HRSNs). CMS has also proposed to remove SDOH measures across the various payment systems it maintains—including home health, inpatient rehabilitation, and skilled nursing—for services provided in 2026.

This measure set is also used for Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program (MSSP). Under MSSP, CMS finalized revisions to rename the "health equity benchmark adjustment" to the "population adjustment," to reflect the adjustment which accounts for the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS) or dually eligible for Medicare and Medicaid.

Table 1. Summary of Policies Impacting 2026 Payments Under the MPFS

The table below summarizes the major payment adjustments affecting audiologists under the 2026 MPFS. It outlines the source of each adjustment, its expected financial impact, and key considerations for different practice settings, providing a concise reference to help audiologists anticipate and plan for potential reimbursement changes.

It's important to note that actual payment depends on several factors, including locality-specific rates and the CPT codes billed. 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.

Policy	What It Is	What It Does	Expected Payment Change (%)	Notes
Conversion Factor (CF)	Annual base multiplier for all MPFS payments.	▪ **$33.57** (APM participants) ▪ **$33.40** (all others)	3.3% to 3.8% increase	Most audiologists will use the $33.40 CF.
MACRA Annual Update	Congressionally-mandated payment update.	Increases the CF annually by: ▪ **0.75%** (APM participants) ▪ **0.25%** (all others)	Contributes to the CF increase noted above.	Applies beginning 2026; *part* of the positive CF update, not *in addition to*.
OBBBA Update	Congressionally-mandated one-time increase to the CF.	Increases the 2026 CF by 2.5%.	Contributes to the CF increase noted above.	Applies only in 2026; *part* of the positive CF update, not *in addition to*. Does not fully mitigate long-standing cuts to the CF since 2021.
Sequestration Cut	Statutory federal budget control mechanism.	Automatic cut to all payments.	2% decrease	Will apply if Congress doesn't act; applied at the claim level.
Efficiency Adjustment	CMS productivity reduction applied select CPT codes.	Reduces work RVUs and time for select diagnostic codes.	2.5% decrease	Excludes codes on the telehealth list (e.g., 92557). Codes subject to the efficiency adjustment are noted in **Table 2 (p. 12)**.
Practice Expense (PE) RVU Changes	Rebalance between non-facility and facility settings.	Increases PE values for non-facility settings and decreases for facility settings.	±Varies	Positive impact for free standing clinics and office settings; negative for SNFs or facility settings other than hospital outpatient departments.
Malpractice (MP) RVU Updates	3-year update to reflect risk/cost changes.	Small reductions to the MP RVU for select audiology codes.	Slight decrease	No MP RVU increases were finalized for audiology codes.

Policy	What It Is	What It Does	Expected Payment Change (%)	Notes
Geographic Practice Cost Index (GPCI)	Update to adjust for local labor and cost differences in addition to removal of the 1.0 for work GPCIs.	Increases or decreases the CF amount based on locality.	±Varies by locality. Decrease up to several % (in low-cost regions).	Localities with work GPCIs below 1.0 will no longer benefit from the mandated floor beyond January 30, 2026, without additional congressional intervention.
MIPS	Quality and performance-based adjustments.	Adjusts payments to eligible clinicians based on performance to reward high-value, high-quality care.	±9% for 2028 payments based on 2026 performance.	Most audiologists are exempt from mandatory reporting; voluntary reporting available.
APMs	Incentive-based value program.	Rewards clinicians who participate in qualifying alternative payment models.	0.75% increase in CF and other incentive payments	A very small number of audiologists participate in qualifying APMs.
Combined Potential Reductions	Aggregate impact of all the above statutory and policy payment adjustments, if left unmitigated.	Cumulative reduction to total payments.	Approximately 3% decrease. ±Varies based on locality, billed codes, and quality reporting adjustments.	ASHA continues to advocate for congressional relief from payment cuts and long-term solutions to stabilize the MPFS.

Table 2. 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 2026 CF (**$33.40**). Because most audiologists are not in a qualifying APM, ASHA used this CF to calculate rates. The table also includes 2025 non-facility rates for comparison with 2026 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. 30**)

Code	Mod	Descriptor	2025 National Fee	2026 National Fee		Notes
			Non-Facility	*Non-Facility*	*Facility*	
92517		Vestibular evoked myogenic potential testing, with interpretation and report; cervical (cVEMP)	$73.43	**$73.48**	**$33.73**	Subject to the efficiency adjustment.
92518		ocular (oVEMP)	$73.75	**$75.15**	**$34.74**	Subject to the efficiency adjustment.
92519		cervical (cVEMP) and ocular (oVEMP)	$118.39	**$117.91**	**$51.10**	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. Subject to the efficiency adjustment.
92537		Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	$37.85	**$39.41**	**N/A**	Subject to the efficiency adjustment.
92537	TC	bithermal...	$8.41	**$9.02**	**N/A**	Subject to the efficiency adjustment.
92537	26	bithermal...	$29.44	**$30.39**	**$30.39**	Subject to the efficiency adjustment.
92538		monothermal (ie, one irrigation in each ear for a total of two irrigations)	$21.35	**$21.71**	**N/A**	Subject to the efficiency adjustment.
92538	TC	monothermal...	$6.15	**$6.35**	**N/A**	Subject to the efficiency adjustment.

Code	Mod	Descriptor	2025 National Fee *Non-Facility*	2026 National Fee		Notes
				Non-Facility	*Facility*	
92538	26	monothermal...	$15.20	**$15.36**	**$15.36**	Subject to the efficiency adjustment.
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	$101.57	**$103.54**	**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. Subject to the efficiency adjustment.
92540	TC	Basic vestibular evaluation…	$28.14	**$29.06**	**N/A**	Subject to the efficiency adjustment.
92540	26	Basic vestibular evaluation…	$73.43	**$74.48**	**$74.48**	Subject to the efficiency adjustment.
92541		Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	$24.26	**$24.72**	**N/A**	Subject to the efficiency adjustment.
92541	TC	Spontaneous nystagmus test…	$4.21	**$4.34**	**N/A**	Subject to the efficiency adjustment.
92541	26	Spontaneous nystagmus test…	$20.05	**$20.37**	**$20.37**	Subject to the efficiency adjustment.
92542		Positional nystagmus test, minimum of 4 positions, with recording	$27.82	**$28.39**	**N/A**	Subject to the efficiency adjustment.
92542	TC	Positional nystagmus test…	$3.88	**$4.01**	**N/A**	Subject to the efficiency adjustment.
92542	26	Positional nystagmus test…	$23.94	**$24.38**	**$24.38**	Subject to the efficiency adjustment.
92544		Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	$17.47	**$17.70**	**N/A**	Subject to the efficiency adjustment.
92544	TC	Optokinetic nystagmus test…	$3.56	**$3.67**	**N/A**	Subject to the efficiency adjustment.
92544	26	Optokinetic nystagmus test…	$13.91	**$14.03**	**$14.03**	Subject to the efficiency adjustment.
92545		Oscillating tracking test, with recording	$16.64	**$16.37**	**N/A**	Subject to the efficiency adjustment.
92545	TC	Oscillating tracking test…	$3.56	**$3.67**	**N/A**	Subject to the efficiency adjustment.
92545	26	Oscillating tracking test…	$12.94	**$12.69**	**$12.69**	Subject to the efficiency adjustment.
92546		Sinusoidal vertical axis rotational testing	$129.06	**$134.61**	**N/A**	Subject to the efficiency adjustment.

Code	Mod	Descriptor	2025 National Fee *Non-Facility*	2026 National Fee		Notes
				Non-Facility	*Facility*	
92546	TC	Sinusoidal vertical axis rotational testing	$114.83	**$119.91**	**N/A**	Subject to the efficiency adjustment.
92546	26	Sinusoidal vertical axis rotational testing	$14.23	**$14.70**	**$14.70**	Subject to the efficiency adjustment.
92547		Use of vertical electrodes (List separately in addition to code for primary procedure)	$10.03	**$11.02**	**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)	$45.29	**$47.43**	**N/A**	Subject to the efficiency adjustment.
92548	TC	CDP-SOT	$13.59	**$14.36**	**N/A**	Subject to the efficiency adjustment.
92548	26	CDP-SOT	$32.02	**$33.07**	**$33.07**	Subject to the efficiency adjustment.
92549		with motor control test (MCT) and adaptation test (ADT)	$62.75	**$62.46**	**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. Subject to the efficiency adjustment.
92549	TC	with MCT and ADT	$19.73	**$19.37**	**N/A**	Subject to the efficiency adjustment.
92549	26	with MCT and ADT	$43.02	**$43.09**	**$43.09**	Subject to the efficiency adjustment.
92550		Tympanometry and reflex threshold measurements	$21.03	**$21.71**	**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	$38.82	**$40.42**	**N/A**	
92553		air and bone	$46.90	**$49.10**	**N/A**	
92555		Speech audiometry threshold;	$29.44	**$29.73**	**N/A**	
92556		with speech recognition	$45.61	**$46.43**	**N/A**	

Code	Mod	Descriptor	2025 National Fee *Non-Facility*	2026 National Fee		Notes
				Non-Facility	*Facility*	
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	$35.26	**$35.74**	**$25.72**	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	$48.20	**$49.10**	**N/A**	
92563		Tone decay test	$34.61	**$35.74**	**N/A**	
92565		Stenger test, pure tone	$21.35	**$22.38**	**N/A**	
92567		Tympanometry (impedance testing)	$15.53	**$16.03**	**$8.68**	
92568		Acoustic reflex testing, threshold	$14.56	**$15.36**	**$12.69**	
92570		Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	$31.05	**$31.40**	**$23.71**	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	$30.73	**$31.06**	**N/A**	
92572		Staggered spondaic word test	$55.64	**$60.46**	**N/A**	
92575		Sensorineural acuity level test	$71.81	**$73.82**	**N/A**	
92576		Synthetic sentence identification test	$43.99	**$42.42**	**N/A**	
92577		Stenger test, speech	$22.32	**$22.71**	**N/A**	
92579		Visual reinforcement audiometry (VRA)	$42.70	**$43.09**	**$29.73**	Subject to the efficiency adjustment.
92582		Conditioning play audiometry	$86.69	**$86.84**	**N/A**	
92583		Select picture audiometry	$58.22	**$61.46**	**N/A**	
92584		Electrocochleography	$104.80	**$105.21**	**N/A**	Subject to the efficiency adjustment.

Code	Mod	Descriptor	2025 National Fee *Non-Facility*	2026 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	$21.03	**$22.04**	**N/A**	See also: CPT Coding for Otoacoustic Emissions
92587	TC	Distortion product evoked otoacoustic emissions…limited	$31.56	**$3.67**	**N/A**	
92587	26	Distortion product evoked otoacoustic emissions…limited	$17.47	**$18.37**	**$18.37**	
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	$32.35	**$33.73**	**N/A**	See also: CPT Coding for Otoacoustic Emissions
92588	TC	Distortion product evoked otoacoustic emissions…comprehensive	$4.85	**$5.01**	**N/A**	
92588	26	Distortion product evoked otoacoustic emissions…comprehensive	$27.49	**$28.72**	**$28.72**	
92596		Ear protector attenuation measurements	$77.63	**$78.16**	**N/A**	
92601		Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	$152.35	**$154.31**	**$98.20**	
92602		subsequent reprogramming	$95.75	**$97.20**	**$55.78**	
92603		Diagnostic analysis of cochlear implant, age 7 years or older; with programming	$143.29	**$145.63**	**$95.86**	
92604		subsequent reprogramming	$86.37	**$87.54**	**$53.47**	
92620		Evaluation of central auditory function, with report; initial 60 minutes	$86.37	**$88.18**	**$64.13**	

Code	Mod	Descriptor	2025 National Fee *Non-Facility*	2026 National Fee		Notes
				Non-Facility	*Facility*	
92621		each additional 15 minutes (List separately in addition to code for primary procedure)	$21.03	**$21.04**	**$15.03**	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	$76.66	**$77.49**	**$53.78**	See also: CPT Code Changes for 2024
92623		each additional 15 minutes (List separately in addition to code for primary procedure)	$19.73	**$20.04**	**$14.03**	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)	$65.02	**$65.80**	**$49.43**	
92626		Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); first hour	$83.45	**$84.50**	**$59.79**	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)	$19.73	**$20.04**	**$14.03**	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	$105.13	**$106.21**	**$75.15**	

Code	Mod	Descriptor	2025 National Fee *Non-Facility*	2026 National Fee		Notes
				Non-Facility	*Facility*	
92651		Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	$76.66	**$80.16**	**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. Subject to the efficiency adjustment.
92652		for threshold estimation at multiple frequencies, with interpretation and report	$105.13	**$107.88**	**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. Subject to the efficiency adjustment.

Code	Mod	Descriptor	2025 National Fee *Non-Facility*	2026 National Fee		Notes
				Non-Facility	*Facility*	
92653		neurodiagnostic, with interpretation and report	$78.93	**$80.16**	**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. Subject to the efficiency adjustment.
92700		Unlisted otorhinolaryngological service or procedure	MAC priced	**MAC Priced**	**MAC Priced**	See also: New Procedures...But No Codes

Table 3. 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 2 (p. 12)** 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	2026 National Fee		Notes
			Non-Facility	*Facility*	
69209		Removal impacted cerumen using irrigation/lavage, unilateral	**$17.03**	**N/A**	Not covered under the audiology benefit.
69210		Removal impacted cerumen requiring instrumentation, unilateral (for bilateral procedure, report 69210)	**$47.76**	**$27.05**	Not covered under the audiology benefit. Subject to the efficiency adjustment.
92516		Facial nerve function studies (eg, electroneuronography)	**$75.15**	**$18.70**	Covered under physician supervision. Subject to the efficiency adjustment.
92531		Spontaneous nystagmus, including gaze	**$0.00**	**$0.00**	Medicare doesn't cover vestibular tests *without* recording. See **92537-92548** in **Table 2** 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	**$13.36**	**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**	**$7.35**	Medicare doesn't cover screenings, but rates are published as reference, when available.

Code	Mod	Descriptor	2026 National Fee		Notes
			Non-Facility	*Facility*	
92590		Hearing aid examination and selection; monaural	**N/A**	**N/A**	**Deleted in 2026**. See **92628-92642** below for new hearing device services codes. See also: CPT Code Changes for 2026
92591		binaural	**N/A**	**N/A**	
92592		Hearing aid check; monaural	**N/A**	**N/A**	
92593		binaural	**N/A**	**N/A**	
92594		Electroacoustic evaluation for hearing aid; monaural	**N/A**	**N/A**	
92595		binaural	**N/A**	**N/A**	
92628		Evaluation for hearing aid candidacy, unilateral or bilateral, including review and integration of audiologic function tests, assessment, and interpretation of hearing needs (eg, speech-in-noise, suprathreshold hearing measures), discussion of candidacy results, counseling on treatment options with report, and, when performed, assessment of cognitive and communication status; first 30 minutes	**$0.00**	**$0.00**	**New in 2026.** Medicare doesn't cover services related to hearing aids. See also: CPT Code Changes for 2026
92629		each additional 15 minutes (List separately in addition to code for primary procedure)	**$0.00**	**$0.00**	
92631		Hearing aid selection services, unilateral or bilateral, including review of audiologic function tests and hearing aid candidacy evaluation, assessment of visual and dexterity limitations, and psychosocial factors, establishment of device type, output requirements, signal processing strategies and additional features, discussion of device recommendations with report; first 30 minutes	**$0.00**	**$0.00**	**New in 2026.** Medicare doesn't cover services related to hearing aids. See also: CPT Code Changes for 2026
92632		each additional 15 minutes (List separately in addition to code for primary procedure)	**$0.00**	**$0.00**	

Code	Mod	Descriptor	2026 National Fee		Notes
			Non-Facility	*Facility*	
92634		Hearing aid fitting services, unilateral or bilateral, including device analysis, programming, verification, counseling, orientation, and training, and, when performed, hearing assistive device, supplemental technology fitting services; first 60 minutes	**$0.00**	**$0.00**	**New in 2026.** Medicare doesn't cover services related to hearing aids. See also: CPT Code Changes for 2026
92635		each additional 15 minutes (List separately in addition to code for primary procedure)	**$0.00**	**$0.00**	
92636		Hearing aid post-fitting follow-up services, unilateral or bilateral, including confirmation of physical fit, validation of patient benefit and performance, sound quality of device, adjustment(s) (eg, verification, programming adjustment[s], device connection[s], and device training), as indicated, and, when performed, hearing assistive device, supplemental technology fitting services; first 30 minutes	**$0.00**	**$0.00**	**New in 2026.** Medicare doesn't cover services related to hearing aids. See also: CPT Code Changes for 2026
92637		each additional 15 minutes (List separately in addition to code for primary procedure)	**$0.00**	**$0.00**	
92638		Behavioral verification of amplification including aided thresholds, functional gain, speech in noise, when performed (List separately in addition to code for primary procedure)	**$0.00**	**$0.00**	**New in 2026.** Medicare doesn't cover services related to hearing aids. This is an add-on code to report in conjunction with 92634 or 92636. See also: CPT Code Changes for 2026
92639		Hearing-aid measurement, verification with probe-microphone (List separately in addition to code for primary procedure)	**$0.00**	**$0.00**	**New in 2026.** Medicare doesn't cover services related to hearing aids. This is an add-on code to report in conjunction with 92634 or 92636. See also: CPT Code Changes for 2026

Code	Mod	Descriptor	2026 National Fee		Notes
			Non-Facility	*Facility*	
92641		Hearing device verification, electroacoustic analysis	**$0.00**	**$0.00**	**New in 2026.** Medicare doesn't cover services related to hearing aids. See also: CPT Code Changes for 2026
92642		Hearing assistive device, supplemental technology fitting services (eg, personal frequency modulation [FM]/digital modulation [DM] system, remote microphone, alerting devices)	**$0.00**	**$0.00**	**New in 2026.** Medicare doesn't cover services related to hearing aids. See also: CPT Code Changes for 2026
92630*		Auditory rehabilitation; prelingual hearing loss	**$0.00**	**$0.00**	Not recognized by Medicare. *Codes out of numerical sequence
92633*		postlingual hearing loss	**$0.00**	**$0.00**	
92650		Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	**$27.05**	**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 Subject to the efficiency adjustment.
95907		Nerve conduction studies; 1–2 studies	**$94.19**	**N/A**	Covered under physician supervision. Subject to the efficiency adjustment.
95907	TC	1–2 studies	**$40.75**	**N/A**	
95907	26	1–2 studies	**$53.44**	**$53.44**	
95908		Nerve conduction studies; 3–4 studies	**$118.57**	**N/A**	Covered under physician supervision. Subject to the efficiency adjustment.
95908	TC	3–4 studies	**$51.44**	**N/A**	
95908	26	3–4 studies	**$67.14**	**$67.14**	
95909		Nerve conduction studies; 5–6 studies	**$141.95**	**N/A**	Covered under physician supervision. Subject to the efficiency adjustment.
95909	TC	5–6 studies	**$61.79**	**N/A**	
95909	26	5–6 studies	**$80.16**	**$80.16**	

Code	Mod	Descriptor	2026 National Fee		Notes
			Non-Facility	*Facility*	
95910		Nerve conduction studies; 7–8 studies	**$184.71**	**N/A**	Covered under physician supervision.
95910	TC	7–8 studies	**$78.49**	**N/A**	
95910	26	7–8 studies	**$106.21**	**$106.21**	Subject to the efficiency adjustment.
95911		Nerve conduction studies; 9–10 studies	**$220.11**	**N/A**	Covered under physician supervision.
95911	TC	9–10 studies	**$87.51**	**N/A**	
95911	26	9–10 studies	**$132.60**	**$132.60**	Subject to the efficiency adjustment.
95912		Nerve conduction studies; 11–12 studies	**$255.18**	**N/A**	Covered under physician supervision.
95912	TC	11–12 studies	**$96.86**	**N/A**	
95912	26	11–12 studies	**$158.32**	**$158.32**	Subject to the efficiency adjustment.
95913		Nerve conduction studies; 13 or more studies	**$300.27**	**N/A**	Covered under physician supervision.
95913	TC	13 or more studies	**$112.56**	**N/A**	
95913	26	13 or more studies	**$187.71**	**$187.71**	Subject to the efficiency adjustment.
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	**$151.64**	**N/A**	Covered under physician supervision.
95925	TC	in upper limbs	**$124.25**	**N/A**	Subject to the efficiency adjustment.
95925	26	in upper limbs	**$27.39**	**$27.39**	
95926		in lower limbs	**$135.94**	**N/A**	Covered under physician supervision.
95926	TC	in lower limbs	**$109.89**	**N/A**	
95926	26	in lower limbs	**$26.05**	**$26.05**	Subject to the efficiency adjustment.
95938*		in upper and lower limbs	**$400.48**	**N/A**	*Out of numerical order. Covered under physician supervision.
95938	TC	in upper and lower limbs	**$355.39**	**N/A**	Subject to the efficiency adjustment.2250
95938	26	in upper and lower limbs	**$45.09**	**$45.09**	
95927		in the trunk or head	**$170.34**	**N/A**	Covered under physician supervision.
95927	TC	in the trunk or head	**$143.29**	**N/A**	
95927	26	in the trunk or head	**$27.05**	**$27.05**	Subject to the efficiency adjustment.

Code	Mod	Descriptor	2026 National Fee		Notes
			Non-Facility	*Facility*	
95930		Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	**$67.80**	**N/A**	Covered under physician supervision. Subject to the efficiency adjustment.
95930	TC	checkerboard or flash	**$49.77**	**N/A**	
95930	26	checkerboard or flash	**$18.04**	**$18.04**	
95937		Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	**$106.55**	**N/A**	Covered under physician supervision. Subject to the efficiency adjustment.
95937	TC	Neuromuscular junction testing…	**$72.48**	**N/A**	
95937	26	Neuromuscular junction testing…	**$34.07**	**$34.07**	
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**	**$26.72**	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) (eg, Epley maneuver, Semont maneuver), per day	**$40.75**	**$29.73**	Not covered under the audiology benefit. Subject to the efficiency adjustment.
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	**$12.36**	**$10.35**	Not covered under the audiology benefit. See also: Use of CTBS Codes
98971		11-20 minutes	**$23.05**	**$19.04**	
98972		21 or more minutes	**$34.40**	**$29.06**	

Code	Mod	Descriptor	2026 National Fee		Notes
			Non-Facility	*Facility*	
98975		Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment	**$21.71**	**N/A**	**New and revised in 2026.** Not covered under the audiology benefit. See also: Use of CTBS Codes *Code out of numerical sequence. Not covered under the audiology benefit.
98984*		device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period	**$41.42**	**N/A**	
98976		device(s) supply for data access or data transmissions to support monitoring of respiratory system, 16-30 days in a 30-day period	**$21.71**	**N/A**	
98985*		device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period	**$40.08**	**N/A**	
98977		device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 16-30 days in a 30-day period	**$40.08**	**N/A**	
98986*		device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period	**MAC priced**	**MAC priced**	
98978		device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period	**MAC priced**	**MAC priced**	
98979		Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes	**$26.39**	**$11.36**	Not covered under the audiology benefit. See also: Use of CTBS Codes
98980		first 20 minutes	**$54.11**	**$25.72**	Not covered under the audiology benefit. See also: Use of CTBS Codes

Code	Mod	Descriptor	2026 National Fee		Notes
			Non-Facility	*Facility*	
98981		each additional 20 minutes (listed separately in addition to code for primary procedure)	**$41.42**	**$25.38**	Not covered under the audiology benefit. See also: Use of CTBS Codes
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**	**$27.39**	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	**$13.03**	**$8.02**	Not covered under the audiology benefit. See also: Use of CTBS Codes Subject to the efficiency adjustment.
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	**$14.03**	**$10.69**	Not covered under the audiology benefit. See also: Use of CTBS Codes

Table 4. Detailed Relative Value Units (RVUs) for Audiology Services

This table contains only RVUs for codes covered under the audiology benefit, as listed in **Table 2** (**p. 12**). For geographically adjusted RVUs, go to Addendum E in the CMS CY 2026 PFS Final Rule Addenda [ZIP] files.

See also: How to Read the MPFS and RVU Tables (**p. 30**)

Code	Mod	Professional Work	Malpractice	Non-Facility Practice Expense	Non-Facility Total	Facility Practice Expense	Facility Total
92517		0.78	0.02	1.40	2.20	0.21	1.01
92518		0.78	0.04	1.43	2.25	0.22	1.04
92519		1.17	0.03	2.32	3.53	0.33	1.53
92537		0.59	0.02	0.57	1.18	N/A	N/A
92537	TC	0.00	0.01	0.26	0.27	N/A	N/A
92537	26	0.59	0.01	0.31	0.91	0.31	0.91
92538		0.29	0.02	0.34	0.65	N/A	N/A
92538	TC	0.00	0.01	0.18	0.19	N/A	N/A
92538	26	0.29	0.01	0.16	0.46	0.16	0.46
92540		1.46	0.02	1.62	3.10	N/A	N/A
92540	TC	0.00	0.01	0.86	0.87	N/A	N/A
92540	26	1.46	0.01	0.76	2.23	0.76	2.23
92541		0.39	0.02	0.33	0.74	N/A	N/A
92541	TC	0.00	0.01	0.12	0.13	N/A	N/A
92541	26	0.39	0.01	0.21	0.61	0.21	0.61
92542		0.47	0.02	0.36	0.85	N/A	N/A
92542	TC	0.00	0.01	0.11	0.12	N/A	N/A
92542	26	0.47	0.01	0.25	0.73	0.25	0.73
92544		0.26	0.02	0.25	0.53	N/A	N/A
92544	TC	0.00	0.01	0.10	0.11	N/A	N/A
92544	26	0.26	0.01	0.15	0.42	0.15	0.42
92545		0.24	0.02	0.23	0.49	N/A	N/A
92545	TC	0.00	0.01	0.10	0.11	N/A	N/A
92545	26	0.24	0.01	0.13	0.38	0.13	0.38
92546		0.28	0.03	3.72	4.03	N/A	N/A
92546	TC	0.00	0.02	3.57	3.59	N/A	N/A
92546	26	0.28	0.01	0.15	0.44	0.15	0.44
92547		0.00	0.00	0.33	0.33	N/A	N/A
92548		0.65	0.02	0.75	1.42	N/A	N/A
92548	TC	0.00	0.01	0.42	0.43	N/A	N/A
92548	26	0.65	0.01	0.33	0.99	0.33	0.99
92549		0.85	0.02	1.00	1.87	N/A	N/A
92549	TC	0.00	0.01	0.57	0.58	N/A	N/A
92549	26	0.85	0.01	0.43	1.29	0.43	1.29
92550		0.35	0.01	0.29	0.65	N/A	N/A
92552		0.00	0.01	1.20	1.21	N/A	N/A

Code	Mod	Professional Work	Malpractice	Non-Facility Practice Expense	Non-Facility Total	Facility Practice Expense	Facility Total
92553		0.00	0.01	1.46	1.47	N/A	N/A
92555		0.00	0.01	0.88	0.89	N/A	N/A
92556		0.00	0.01	1.38	1.39	N/A	N/A
92557		0.60	0.01	0.46	1.07	0.16	0.77
92562		0.00	0.01	1.46	1.47	N/A	N/A
92563		0.00	0.01	1.06	1.07	N/A	N/A
92565		0.00	0.01	0.66	0.67	N/A	N/A
92567		0.20	0.01	0.27	0.48	0.05	0.26
92568		0.29	0.01	0.16	0.46	0.08	0.38
92570		0.55	0.01	0.38	0.94	0.15	0.71
92571		0.00	0.01	0.92	0.93	N/A	N/A
92572		0.00	0.01	1.80	1.81	N/A	N/A
92575		0.00	0.02	2.19	2.21	N/A	N/A
92576		0.00	0.01	1.26	1.27	N/A	N/A
92577		0.00	0.01	0.67	0.68	N/A	N/A
92579		0.68	0.01	0.60	1.29	0.20	0.89
92582		0.00	0.01	2.59	2.60	N/A	N/A
92583		0.00	0.01	1.83	1.84	N/A	N/A
92584		098	0.03	2.14	3.15	N/A	N/A
92587		0.35	0.02	0.29	0.66	N/A	N/A
92587	TC	0.00	0.01	0.10	0.11	N/A	N/A
92587	26	0.35	0.01	0.19	0.55	0.19	0.55
92588		0.55	0.02	0.44	1.01	N/A	N/A
92588	TC	0.00	0.01	0.14	0.15	N/A	N/A
92588	26	0.55	0.01	0.30	0.86	0.30	0.86
92596		0.00	0.01	2.33	2.34	N/A	N/A
92601		2.30	0.01	2.31	4.62	0.63	2.94
92602		1.30	0.01	1.60	2.91	0.36	1.67
92603		2.25	0.01	2.10	4.36	0.61	2.87
92604		1.25	0.01	1.36	2.62	0.34	1.60
92620		1.50	0.01	1.13	2.64	0.41	1.92
92621		0.35	0.00	0.28	0.63	0.10	0.45
92622		1.25	0.01	1.06	2.32	0.35	1.61
92623		0.33	0.00	0.27	0.60	0.09	0.42
92625		1.15	0.02	0.80	1.97	0.31	1.48
92626		1.40	0.01	1.12	2.53	0.38	1.79
92627		0.33	0.00	0.27	0.60	0.09	0.42
92640		1.76	0.01	1.41	3.18	0.48	2.25
92651		0.98	0.04	1.38	2.40	N/A	N/A
92652		1.46	0.07	1.70	3.23	N/A	N/A
92653		1.02	0.05	1.33	2.40	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 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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