2026

Medicare Fee Schedule for Speech-Language Pathologists

ASHA
Speech-Language Pathology
Dedicated to Advancing the Profession of Speech-Language Pathology

1116300

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 speech-language pathologists (SLPs) with their national average payment amounts, and useful links to additional information.

SLPs should always contact their local Medicare Administrative Contractor for final rates and coverage guidelines.

ASHA's Medicare outpatient payment website provides additional information regarding the MPFS, including background information, instructions for calculating Medicare payment, and speech-language pathology specific payment and coding rules. If you have any questions, contact reimbursement@asha.org.

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Overview

Outpatient speech-language pathology services provided under Part B of the Medicare program are paid under the Medicare Physician Fee Schedule (MPFS). This document summarizes regulations and rates for **implementation on January 1, 2026**, for speech-language pathologists (SLPs) providing services to Medicare Part B beneficiaries under the MPFS. Key policies addressed in this analysis include coding updates; telehealth services; quality reporting; alternative payment models (APMs); and national payment rates for speech-language pathology related services.

The 2026 MPFS includes modest payment updates but continues to place downward pressure on speech-language pathology 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 4% without additional legislative intervention.

In addition, the CMS finalized permanent telehealth coverage for speech-language pathology codes—though congressional action has only extended coverage for SLPs through January 30, 2026—and maintained policies related to therapy payment, including the multiple procedure payment reduction (MPPR) and targeted manual medical review. Most SLPs 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 and extend telehealth authority.

ASHA's Medicare outpatient payment resources provide additional information on the MPFS, including background information, instructions for calculating Medicare payment, and speech-language pathology payment and coding rules. If you have any questions, please contact reimbursement@asha.org.

Analysis of the 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 SLPs.

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 in the 2.5% update in 2026—SLPs 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 4%. ASHA members should prepare for a reduction effective January 1, 2026. Although Congress has mitigated these cuts the past several years, policy and political dynamics may push potential action to next year, after the cuts take effect. ASHA will continue to monitor and provide updates as the situation evolves.

ASHA strongly encourages SLPs to contact their members of Congress and ask them to address the Medicare cuts before the end of the year.

Conversion Factor (CF)

CMS uses the CF to calculate MPFS payment rates. 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 SLPs 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 to Speech-Language Pathology Services

CMS also 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 SLPs will experience between a negative 1% to a negative 2% shift in payment in 2025 in *addition* to the adjustment to the CF.

However, Medicare providers also 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 SLPs face could reach 4% 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. ASHA continues to advocate for legislation to address these annual reductions and ensure SLPs are aware of the potential impact on their Medicare payments.

It is important to note that the estimated impacts calculated by CMS reflect average payments based on cumulative therapy spending under the MPFS. However, it may not reflect the changes experienced by individual SLPs or practices, as actual payment depends on several factors, including locality-specific rates and the CPT codes billed. For example, CPT code 92507 (speech, language, communication treatment) will see a 2% increase to the national payment rate while CPT code 96112 (developmental test administration) will experience a 1% decrease. As a result, SLPs wishing to determine the actual impact of the payment changes to their practice should calculate payments based on their specific billing patterns and locality.

See Table 1 (p. 11) for a summary of the various factors impacting 2026 MPFS payments. **See Table 2 (p. 13)** for a listing of speech-language pathology procedures and corresponding national payment rates. The table also includes 2025 non-facility rates for comparison with 2026 rates to help SLPs 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 total RVUs for any CPT code is multiplied by the CF to determine the corresponding fee. **See Table 4 (p. 25)** for a detailed chart of final 2026 RVUs.

ASHA, through its Health Care Economics Committee, works with related specialty and physician groups to present data to the American Medical Association Relative Value Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC) to maintain and update the speech-language pathology code set and ensure the SLP's time and effort is appropriately captured in professional work. Professional work RVUs rarely change over time, unlike practice expense values that fluctuate according to CMS payment formula policies. ASHA will continue to recommend professional work values for speech-language pathology services, as warranted. See ASHA's infographic for more information on the CPT code development and valuation process [PDF].

Practice Expense 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 SLPs, the impact will have an overall positive impact on payments under the MPFS, since speech-language pathology services, by law, are paid at the non-facility rate regardless of setting.

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 SLPs 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 92507 (treatment of speech, language, voice, communication, and/or auditory processing

disorder; individual) 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
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	47 min	46.25 min	1.34	1.31	$92.52	$91.52

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 speech-language pathology 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 speech-language pathology services did not change, CMS has finalized additional reductions to MP values for certain speech-language pathology codes and did not provide significant 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.

Multiple Procedure Payment Reductions (MPPR)

The MPPR policy for speech-language pathology and other services will continue in 2026. Under this system, per-code payment is decreased when multiple therapy services are performed for a single beneficiary on the same day. This per-day policy applies to services provided by all therapy disciplines (i.e., speech-language pathology, physical therapy, and occupational therapy) in the same facility. It is important to note that CPT codes for services typically billed by SLPs are less susceptible to MPPR reductions because most are untimed service-based codes with higher values than timed codes typically billed by occupational and physical therapists. Visit ASHA's website for more information on MPPR, including billing scenarios and a list of the speech-language pathology codes subject to MPPR.

CPT Code Updates

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

Remote Therapeutic Monitoring (RTM)

Beginning January 1, 2026, CMS will implement several key updates to the RTM code set (98974 through 98986) to expand billing flexibility and better reflect how clinicians use digital tools to support patient care. These updates introduce new CPT codes that allow for **shorter durations of device use and clinician interaction**, addressing long-standing concerns that the existing RTM thresholds were too rigid for many therapy scenarios.

Currently, providers can only bill RTM device supply codes (such as 98976 and 98977) if a monitoring device transmits therapeutic data for **at least 16 days** within a 30-day period. Similarly, RTM treatment management codes (98980 and 98981) require **at least 20 minutes** of interactive communication with the patient or caregiver in a calendar month. These thresholds often limited the use of RTM to longer-term monitoring programs, leaving gaps for shorter interventions—for example, when clinicians monitor adherence to a home program for two weeks or perform brief check-ins after a therapy adjustment.

To address this, CMS finalized new RTM device supply codes (CPT codes 98979, 98984, 98985, and 98986) that permit billing when the device captures and transmits data for **only two to 15 days** within a 30-day period. This change allows billing for shorter monitoring episodes while retaining the existing codes for longer (16-to-30-day) monitoring. CMS also finalized a new RTM treatment management code, 98979, that can be billed when a clinician provides **10 to 19 minutes** of interactive communication and management services in a calendar month, complementing the existing 20-minute threshold codes. In addition, existing CPT codes 98976, 98977, and 98978 have been revised to report **16 to 30 days** of data transmission per 30-day period.

The new codes are designed to apply across musculoskeletal, respiratory, and cognitive-behavioral monitoring categories—maintaining the same clinical intent as the current RTM code family while recognizing that not all monitoring requires 16 days of data or 20 minutes of provider time.

However, it is important to note that documentation requirements remain unchanged. SLPs should only report RTM codes when services are provided under a specific therapy plan of care to report results of monitoring to manage a patient. Any device used must be a medical device defined and approved by the FDA. SLPs must still record the duration of monitoring, number of data transmission days, nature of the device used, and the details of any interactive communication with the patient. In addition, some of the new device supply codes will be subject to local Medicare Administrative Contractor (MAC) pricing, meaning payment amounts may vary regionally.

See ASHA's website for more information on billing virtual services, including RTM.

Targeted Manual Medical Review

CMS notes in the final rule that the Bipartisan Budget Act of 2018 permanently repealed the hard caps on therapy services and permanently extended the targeted medical review process first applied in 2015. Therefore, Medicare beneficiaries can continue to receive medically necessary treatment with no arbitrary payment limitations. The threshold that triggers potential medical review is $3,000 for speech-language pathology and physical therapy combined. There is also a "KX" modifier threshold, at which point clinicians must report the "KX" modifier on the claim to demonstrate continued medical need for services. The KX modifier threshold for 2026 is **$2,480** for physical therapy and speech-language pathology services, combined. ASHA's website provides more information regarding the targeted manual medical review process.

Medicare Telehealth Services

After extensive ASHA advocacy, CMS finalized a policy that the CPT codes used by SLPs will remain permanently included on the list of covered Medicare telehealth services. This means all speech-language pathology 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 SLPs—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 SLPs to receive reimbursement for services provided via telehealth at parity with payment for in-person services. SLPs can advocate for permanent congressional authority to be telehealth providers under Medicare by urging Congress to support the Expanded Telehealth Access Act.

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.

Telesupervision of "Incident To" Services

SLPs, physical therapists (PTs), and occupational therapists (OTs) are allowed to provide services "incident to" a physician with direct supervision. "Incident to" coverage policies state that the services of the therapist would be billed under the National Provider Identifier (NPI) of the supervising physician. Direct supervision is typically defined as *in the office suite and immediately available to help if needed*. This definition was relaxed during the COVID-19 public health emergency to allow for telesupervision—supervision via real-time audio and visual interactive telecommunications.

In response to numerous requests from ASHA to maintain this policy, **CMS will continue to allow telesupervision permanently** for physical and occupational therapy and speech-language pathology services.

The Quality Payment Program (QPP)

The QPP transitions Medicare payments away from a volume-based fee-for-service payment to a more value-based system of quality and outcomes-based reimbursement. The program includes the Merit-based Incentive Payment System and Advanced Alternative Payment Models. ASHA's website provides more information on the QPP.

Merit-Based Incentive Payment System (MIPS)

MIPS represents one track of the QPP that focuses on quality improvement in fee-for-service Medicare. SLPs first became eligible for MIPS for 2019 and will continue to participate in the program in 2026. If an SLP 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 SLPs will 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 SLPs—must report a minimum of six measures when/if six measures apply. In 2026, SLPs have 10 applicable measures after CMS eliminated two measures associated with social determinants of health (SDOH). This means that SLPs have the flexibility to select measures to meet the minimum reporting requirement of six measures. For additional information, CMS provides extensive resources on MIPS on its website.

- Measure 130: Documentation of Current Medications in the Medical Record
- Measure 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Measure 181: Elder Maltreatment Screen and Follow-Up Plan
- Measure 182: Functional Outcome Assessment
- Measure 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Measure 282: Dementia: Functional Status Assessment: Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.
- Measure 286: Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia: Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety concerns screening in two domains of risk: (1) dangerousness to self or others and (2) environmental risks; and if safety concerns screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.
- Measure 288: Dementia: Education and Support of Caregivers for Patients with Dementia: Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months.
- Measure 291: Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease
- Measure 386: Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences: Percentage of patients diagnosed with ALS who were offered assistance in planning for end of life issues (e.g., advance directives, invasive ventilation, lawful physician-hastened death, hospice) or whose existing end of life plan was reviewed or updated at least once annually or more frequency as clinically indicated (i.e., rapid progression).

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.

For the IA performance category, SLPs 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.”

SLPs 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 SLPs participate in the second track of the QPP, the APM track. These clinicians typically work for larger health care systems and have the support of finance and administration departments to manage the complexity of such models. SLPs 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). CMS also 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 SLPs 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 SLPs 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. SLPs wishing to determine the actual impact of the payment changes to their practice should calculate payments based on their specific billing patterns and locality.

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 SLPs 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., 92507). Codes subject to the efficiency adjustment are noted in **Table 2 (p. 13)**.
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 across settings; speech-language pathology services are paid at the non-facility rate regardless of setting.
Malpractice (MP) RVU Updates	3-year update to reflect risk/cost changes.	Small reductions to the MP RVU for select codes.	Slight decrease	Minimal MP RVU increases were finalized for speech-language pathology 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 SLPs 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 SLPs 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 4% 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 Speech-Language Pathology Services

The following table contains full descriptors and national payment rates for speech-language pathology-related services. ASHA calculated rates by multiplying the total RVUs for each CPT code by the updated 2026 CF (**$33.40**). Because most SLPs 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 SLPs estimate the impact of the payment cuts. Please see ASHA's Medicare outpatient payment website for other important information, including Medicare fee calculations and how to find rates by locality.

Medicare pays for outpatient speech-language pathology services at non-facility rates, regardless of setting. All claims should be accompanied by the "GN" modifier to indicate services are provided under a speech-language pathology plan of care. Please see ASHA's Medicare CPT Coding Rules for Speech-Language Pathology Services for additional coding guidance.

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
31579	Laryngoscopy, flexible or rigid telescopic; with stroboscopy	$190.52	**$195.06**	This procedure may require physician supervision based on your Medicare Administrative Contractor's (MAC's) local coverage policy or state practice act. See ASHA's website for more information. Subject to efficiency adjustment.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	$75.04	**$76.15**	SLPs may also use 92507 to report auditory (aural) rehabilitation.
92508	group, 2 or more individuals	$23.61	**$24.05**	See also: Medicare Guidelines for Group Therapy and Modes of Service Delivery for Speech-Language Pathology
92511	Nasopharyngoscopy with endoscope (separate procedure)	$111.92	**$115.90**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act. See ASHA's website for more information. Subject to efficiency adjustment.
92512	Nasal function studies (eg, rhinomanometry)	$62.43	**$65.13**	Subject to efficiency adjustment.
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	$87.66	**$90.85**	Subject to efficiency adjustment.
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	$130.68	**$133.27**	

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	$108.68	**$111.89**	Don't bill 92522 in conjunction with 92523.
92523	with evaluation of language comprehension and expression (eg, receptive and expressive language)	$223.51	**$226.46**	Don't bill 92523 in conjunction with 92522.
92524	Behavioral and qualitative analysis of voice and resonance	$106.74	**$109.22**	This procedure doesn't include instrumental assessment.
92526	Treatment of swallowing dysfunction and/or oral function for feeding	$82.81	**$84.17**	See also: Answers to Your Feeding/Swallowing Coding Questions
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	$71.16	**$71.14**	Subject to efficiency adjustment.
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	$120.98	**$122.58**	See also: Billing for AAC and Device Documentation
92608	each additional 30 minutes (List separately in addition to code for primary procedure)	$47.55	**$47.76**	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	$100.92	**$102.60**	See also: Billing for AAC and Device Documentation
92610	Evaluation of oral and pharyngeal swallowing function	$83.45	**$84.84**	See also: Answers to Your Feeding/Swallowing Coding Questions
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	$88.95	**$91.52**	92611 reflects the SLP's work during the study. Radiologists separately report 74230 (see Table 2) to report their participation in the study. See also: Answers to Your Feeding/Swallowing Coding Questions Subject to efficiency adjustment.

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;	$193.43	**$199.74**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act. See also: Answers to Your Feeding/Swallowing Coding Questions Subject to efficiency adjustment.
92613	interpretation and report only	$35.26	**$35.74**	SLPs may report 92613 when you haven't performed the endoscopic evaluation but are asked to review and interpret the study. Don't use this code if you also perform the endoscopy. MACs may limit use of this code based on their local coverage policies. Subject to efficiency adjustment.
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	$145.88	**$151.64**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act. Subject to efficiency adjustment.
92615	interpretation and report only	$31.38	**$32.06**	SLPs may report 92615 when you haven't performed the endoscopic evaluation but are asked to review and interpret the study. Don't use this code if you also perform the endoscopy. MACs may limit use of this code based on their local coverage policies. Subject to efficiency adjustment.
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;	$224.48	**$228.80**	This procedure may require physician supervision based on your MAC's local coverage policy or state practice act. Subject to efficiency adjustment.
92617	interpretation and report only	$39.14	**$39.75**	SLPs may report 92617 when you haven't performed the endoscopic evaluation but are asked to review and interpret the study. Don't use this code if you also perform the endoscopy. MACs may limit use of this code based on their local coverage policies. Subject to efficiency adjustment.

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	$83.45	**$84.17**	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**	This is an add-on code to report in conjunction with 92626 for each additional 15 minutes of evaluation.
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	$93.80	**$97.20**	
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	$127.12	**$125.25**	
96113	each additional 30 minutes (List separately in addition to code for primary procedure)	$53.37	**$56.11**	
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	$99.63	**$102.87**	See also: Coding and Payment of Cognitive Evaluation and Treatment Services

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	$21.67	**$22.38**	See also: Coding and Payment of Cognitive Evaluation and Treatment Services
97130	each additional 15 minutes (List separately in addition to code for primary procedure)	$20.70	**$21.04**	This is an add-on code to report in conjunction with 97129 for each additional 15 minutes of therapy.
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes	$60.49	**$60.79**	SLPs should verify use of the Physical Medicine & Rehabilitation (PMR) series of codes with the MAC, with the exception of 97129 and 97130. See also: Use of Physical Medicine Codes
97535	Self-care/home management training (eg, activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	$32.02	**$32.40**	SLPs should verify use of the PMR series of codes with the MAC, with the exception of 97129 and 97130. See also: Use of Physical Medicine Codes
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes	$52.08	**$52.77**	See also: 2024 CPT Code Changes

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
97551	each additional 15 minutes (List separately in addition to code for primary procedure)	$25.55	**$26.05**	This is an add-on code to report in conjunction with 97550 for each additional 15 minutes of training.
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	$22.00	**$22.04**	See also: 2024 CPT Code Changes
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	$11.32	**$12.36**	See also: Use of CTBS Codes
98971	11-20 minutes	$21.35	**$23.05**	
98972	21 or more minutes	$32.35	**$34.40**	
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment	$19.73	**$21.71**	**New and revised in 2026.** See 2026 CPT Code Changes. See also: Use of CTBS Codes *Code out of numerical sequence
98984*	device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period	N/A	**$47.43**	
98976	device(s) supply for data access or data transmissions to support monitoring of respiratory system, 16-30 days in a 30-day period	$43.02	**$47.43**	

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
98985*	device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period	N/A	**$40.08**	
98977	device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 16-30 days in a 30-day period	$43.02	**$40.08**	
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	N/A	**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	N/A	**$26.39**	**New and revised in 2026.** See 2026 CPT Code Changes. See also: Use of CTBS Codes 98981 is the add-on code to report in conjunction with 98980 for each additional 20 minutes of RTM treatment services during the calendar month.
98980	first 20 minutes	$50.14	**$54.11**	
98981	each additional 20 minutes (listed separately in addition to code for primary procedure)	$39.14	**$41.42**	
G0451	Developmental testing, with interpretation and report, per standardized instrument form	$11.32	**$12.36**	This Medicare-specific HCPCS Level II code can be used in place of CPT 96110, which isn't paid by Medicare.

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
G0541	Caregiver training in direct care strategies and techniques to support care for patients with ongoing conditions or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes	$52.08	**$53.11**	See also: 2025 HCPCS Code Changes.
G0542	each additional 15 minutes (List separately in addition to code for primary service)	$25.55	**$26.05**	This is an add-on code to report in conjunction with G0452 for each additional 15 minutes of training.
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers	$22.00	**$22.04**	See also: 2025 HCPCS Code Changes.
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	$11.97	**$13.03**	See also: Use of CTBS Codes Subject to efficiency adjustment.

Code	Descriptor	2025 National Fee	2026 National Fee	Notes
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	$13.91	**$14.03**	See also: Use of CTBS Codes
92700	Unlisted otorhinolaryngological service or procedure	MAC priced	**MAC priced**	Report 92700 for a covered Medicare service that does not have a corresponding CPT code. See also: New Procedures...But No Codes

Table 3. National Medicare Part B Rates for Non-Benefit Services or Other CPT Codes of Interest

SLPs may not directly bill Medicare for the following procedures, which are listed for informational purposes only. Although some of these procedures are within the scope of practice of an ASHA-certified SLP, some services—such as screenings—are specifically excluded from the Medicare benefit or are not recognized for billing when performed by an SLP. Rates are included for reference only, when available. Please see **Table 2 (p. 13)** for services and procedures SLPs may bill directly to Medicare.

Code	Descriptor	2026 National Fee	Notes
31575	Laryngoscopy, flexible; diagnostic	**$127.26**	This procedure is for medical diagnosis by a physician. Subject to efficiency adjustment.
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	**$111.22**	This is a radiology code. Subject to efficiency adjustment.
74230	Swallowing function, with cineradiography/videoradiography	**$120.24**	This is a radiology code. See CPT code **92611** for the appropriate speech-language pathology procedure. Subject to efficiency adjustment.
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	**$108.89**	This is a radiology code. Subject to efficiency adjustment.
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	**$93.19**	CMS won't pay for this code because it is considered bundled with any other speech-language pathology service provided on the same day. SLPs may not separately bill for non-speech-generating device services alone.
92618*	each additional 30 minutes (List separately in addition to code for primary procedure)	**$33.07**	*Code out of numerical sequence. See note for 92605.
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	**$79.49**	CMS won't pay for this code because it is considered a bundled service included in other speech-language pathology services provided on the same day. SLPs may not separately bill for non-speech-generating device services alone. Subject to efficiency adjustment.

Code	Descriptor	2026 National Fee	Notes
92630	Auditory rehabilitation; prelingual hearing loss	**$0.00**	This is a non-payable code. However, auditory (aural) rehabilitation is a covered Medicare benefit, so CMS instructs SLPs to use **92507** instead.
92633	postlingual hearing loss	**$0.00**	This is a non-payable code. However, auditory (aural) rehabilitation is a covered Medicare benefit, so CMS instructs SLPs to use **92507** instead.
96119	Developmental screening, with interpretation and report, per standardized instrument form	**$12.36**	Medicare does not pay for screenings. See HCPCS code **G0451** for developmental testing using a standardized instrument form.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	**$29.06**	This is a PMR code. CMS won't pay for this code when reported by an SLP. See also: Use of Physical Medicine Codes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	**$32.73**	This is a PMR code. CMS won't pay for this code when reported by an SLP. See also: Use of Physical Medicine Codes
97150	Therapeutic procedure(s), group (2 or more individuals)	**$18.04**	This is a PMR code. Generally, CMS won't pay for this code when reported by an SLP. However, some MACs may allow SLPs to report 97150 for group therapy for conditions not covered under 92508, such as cognition or dysphagia. See also: Medicare Guidelines for Group Therapy and Modes of Service Delivery for Speech-Language Pathology
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	**$35.07**	This is a PMR code. CMS won't pay for this code when reported by an SLP. See also: Use of Physical Medicine Codes

Code	Descriptor	2026 National Fee	Notes
G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	**$28.39**	CMS won't pay for this code when reported by an SLP.

Table 4. Detailed Relative Value Units (RVUs) for Speech-Language Pathology Services

This table contains RVUs only for those codes that are covered under the speech-language pathology benefit, as listed in **Table 2 (p. 13)**. For geographically adjusted RVUs, go to Addendum E in the CMS CY 2026 PFS Final Rule Addenda [ZIP] files.

Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
31579	1.83	3.77	0.24	5.84
92507	1.30	0.97	0.01	2.28
92508	0.33	0.38	0.01	0.72
92511	0.59	2.84	0.04	3.47
92512	0.54	1.37	0.04	1.95
92520	0.73	1.97	0.02	2.72
92521	2.24	1.74	0.01	3.99
92522	1.92	1.39	0.04	3.35
92523	3.84	2.93	0.01	6.78
92524	1.92	1.32	0.03	3.27
92526	1.34	1.17	0.01	2.52
92597	1.23	0.88	0.02	2.13
92607	1.85	1.81	0.01	3.67
92608	0.70	0.73	0.00	1.43
92609	1.50	1.56	0.01	3.07
92610	1.30	1.23	0.01	2.54
92611	1.31	1.38	0.05	2.74
92612	1.24	4.69	0.05	5.98
92613	0.69	0.34	0.04	1.07
92614	1.24	3.24	0.06	4.54
92615	0.61	0.31	0.04	0.96
92616	1.83	4.95	0.07	6.85
92617	0.77	0.37	0.05	1.19
92626	1.40	1.11	0.01	2.52
92627	0.33	0.27	0.00	0.60
96105	1.75	1.11	0.05	2.91
96112	2.56	1.05	0.14	3.75
96113	1.16	0.49	0.03	1.68
96125	1.70	1.34	0.04	3.08
97129	0.50	0.16	0.01	0.67
97130	0.48	0.15	0.00	0.63
97533	0.48	1.33	0.01	1.82
97535	0.45	0.51	0.01	0.97
97550	1.00	0.57	0.01	1.58
97551	0.54	0.24	0.00	0.78

Code	Professional Work	Non-Facility Practice Expense	Malpractice	Non-Facility Total
97552	0.23	0.42	0.01	0.66
98970	0.25	0.11	0.01	0.37
98971	0.44	0.23	0.02	0.69
98972	0.69	0.31	0.03	1.03
98975	0.00	0.63	0.02	0.65
98976	0.00	1.41	0.01	1.42
98977	0.00	1.19	0.01	1.20
98978	0.00	0.00	0.00	0.00
98979	0.31	0.47	0.01	0.79
98980	0.62	0.97	0.03	1.62
98981	0.61	0.60	0.03	1.24
98984	0.00	1.41	0.01	1.42
98985	0.00	1.19	0.01	1.20
98986	0.00	0.00	0.00	0.00
G0451	0.00	0.36	0.01	0.37
G0541	1.00	0.58	0.01	1.59
G0542	0.54	0.24	0.00	0.78
G0543	0.23	0.42	0.01	0.66
G2250	0.18	0.20	0.01	0.39
G2251	0.25	0.16	0.02	0.43

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