MEDICARE REIMBURSEMENT BRIEFING

CPT 92507 & Medicare RVUs

What the CY 2027 CMS Proposed Rule Means for SLPs

Current valuation of 92507, CMS's proposed new codes and payment, the new pediatric G code, and how to submit a comment.

Source: ASHA / CMS CY 2027 MPFS Proposed Rule (CMS-1848-P) · Prepared July 2026

Current RVUs for CPT 92507

WORK (SKILL) RVU

1.30

Skill / clinician effort only.
This 1.30 reflects the professional work of the SLP — it does not include practice expense or malpractice.

Total RVUs are built from three components

Work RVU (skill / clinician effort)	**1.30**
Practice expense (PE) RVU*	**0.90**
Malpractice (MP) RVU*	**0.08**
Total RVUs	**2.28**

≈ $76.15 national Medicare non-facility payment (2026). **PE and MP shown as CMS national non-facility values; the three components sum to the 2.28 total. Actual payment varies by locality (GPCI) and the annual conversion factor.*

92507 is being replaced on January 1, 2027

After more than two decades as the catch-all code for individual SLP treatment, **CPT 92507 will be deleted** and replaced by a family of **10 new time-based codes.**

- **Five clinical code pairs** — One base code + one add-on code for each clinical service category.
- **Time-based reporting** — Codes reflect the clinical service and direct treatment time delivered.
- **92508 retained** — Group treatment stays a stand-alone, untimed code — no major change.
- **Why the change** — A 2024 utilization review triggered revaluation of a 15-year-old code.

THROUGH DEC 31, 2026

CPT 92507

One code for most individual treatment

FROM JAN 1, 2027

10 new treatment codes

5 base + 5 add-on, by clinical service and time

+ 92508 group treatment code retained (untimed)

What CMS proposed for the new codes

CMS accepted the RUC/HCPAC-recommended work RVUs and direct practice-expense inputs for all 10 new codes without changes

An important recognition of the professional work and resources required to furnish these services.

Values are proposed

The rule sets initial Medicare Part B values. Final RVUs and payment rates are locked in the CY 2027 final rule, expected fall 2026.

Base + add-on structure

Each clinical category has a base code plus a time-based add-on, so payment tracks the actual treatment time delivered.

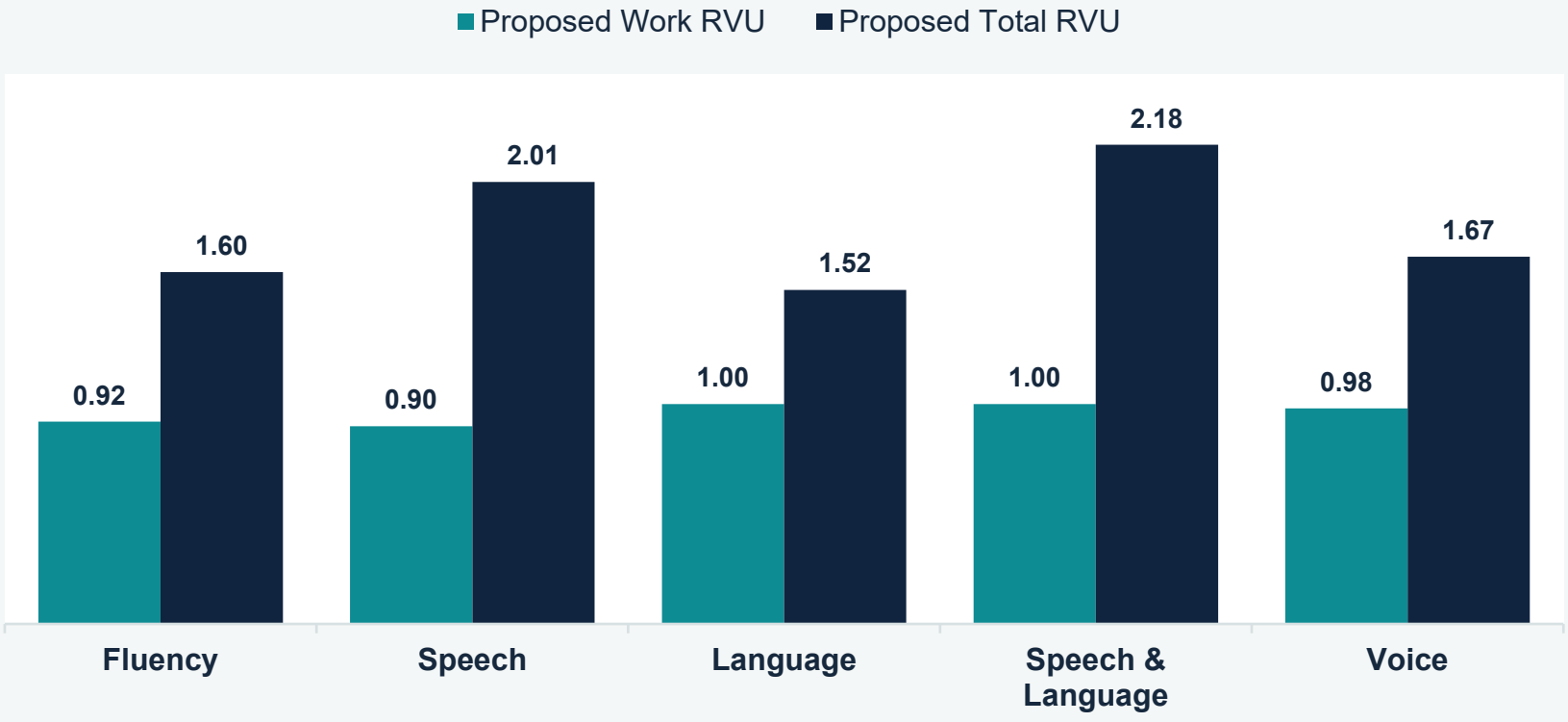
Public Comment Period

Professionals can comment on proposed RVUs through September 14, 2026 at 5:00p EST

Figures apply to Medicare Part B; commercial and Medicaid payers set their own rates and timelines.

Proposed RVUs by domain area

Initial 30-minute base code for each clinical service — proposed work RVU vs. total RVU (CY 2027 proposed rule).



HIGHEST PROPOSED VALUE

Speech & Language

2.18 total RVU · $71.59

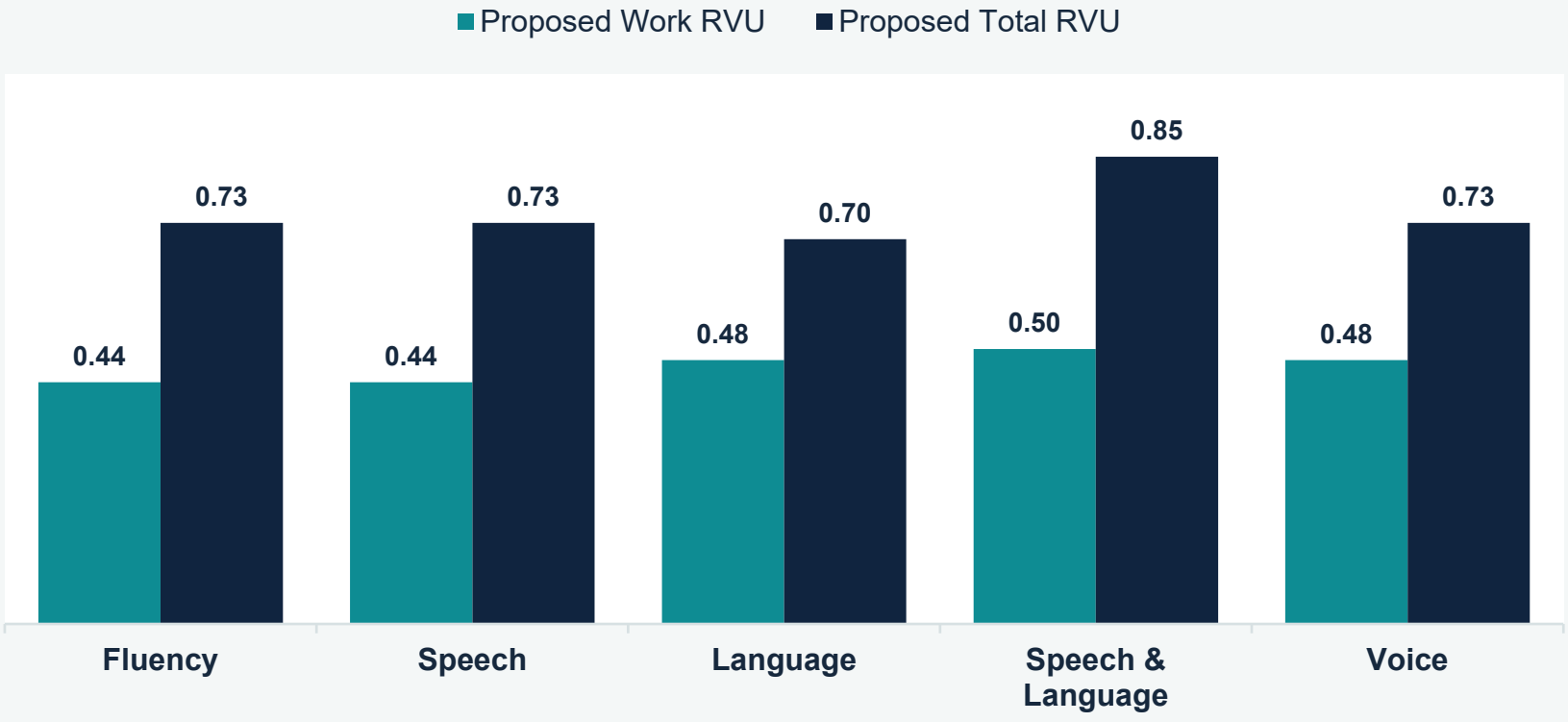
EST. NATIONAL PAYMENT

Fluency	**$52.55**
Speech	**$66.01**
Language	**$49.92**
Speech & Language	**$71.59**
Voice	**$54.84**

Base (initial 30 min) codes shown. Each service also has an add-on code for every additional 15 minutes. *Source: ASHA / CMS CY 2027 MPFS Proposed Rule (CMS-1848-P).*

Proposed add-on RVUs by domain area

Each additional 15 minutes of treatment — proposed work RVU vs. total RVU for the add-on codes (CY 2027 proposed rule).



HIGHEST PROPOSED VALUE

Speech & Language

92X7X · 0.85 total RVU · $27.91

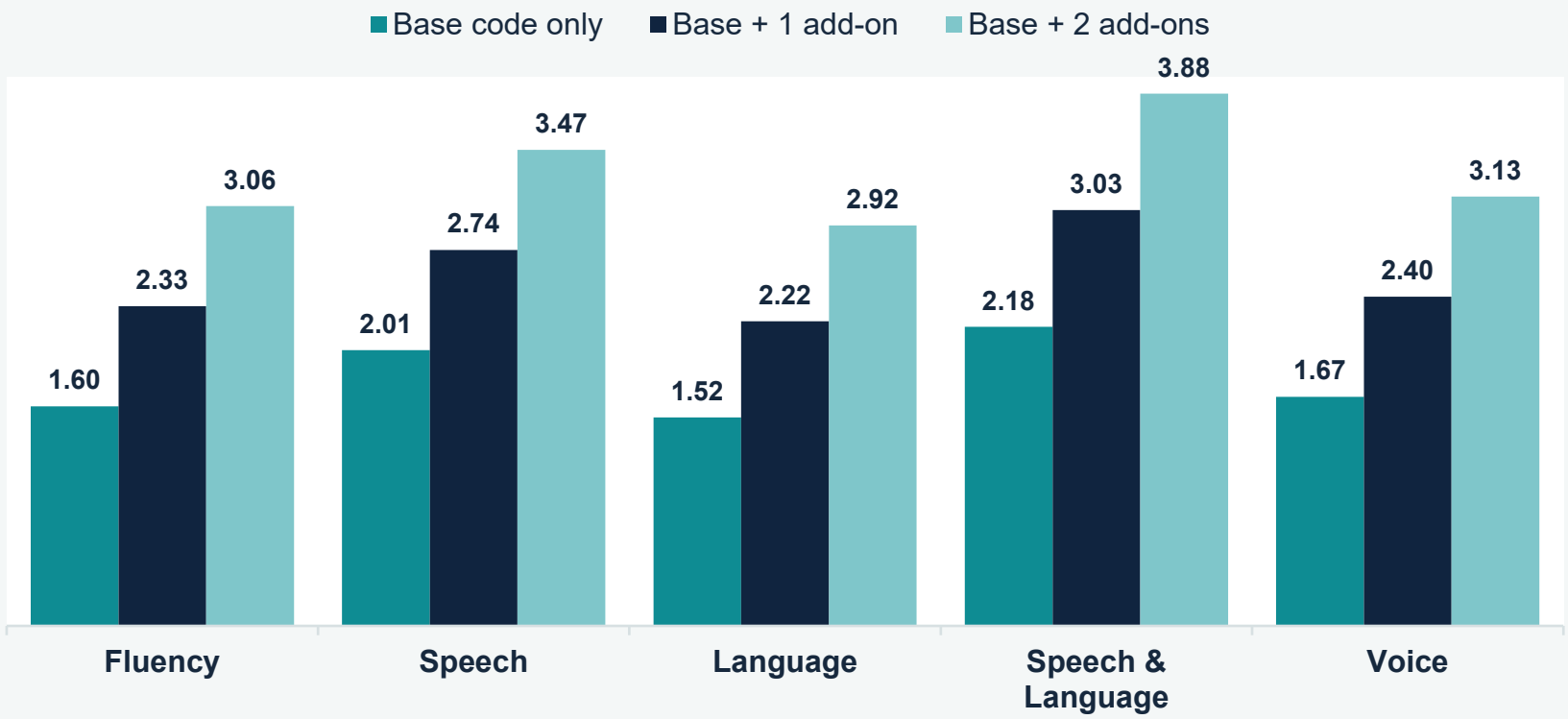
EST. NATIONAL PAYMENT

Fluency	**$23.97**
Speech	**$23.97**
Language	**$22.99**
Speech & Language	**$27.91**
Voice	**$23.97**

Add-on codes are reported for each additional 15 minutes alongside the base code; placeholder codes shown. *Source: ASHA / CMS CY 2027 MPFS Proposed Rule (CMS-1848-P).*

Proposed RVUs when you add 15-minute units

Total proposed RVUs by domain — base code alone, base + one 15-minute add-on, and base + two add-ons.



Comparison: 2.28 total RVU for 92507 · $76.15

HIGHEST STACKED VALUE

Speech & Language, base + 2 add-ons

3.88 total RVU · $127.41

EST. PAYMENT, BASE + 2 ADD-ONS

Fluency	**$100.49**
Speech	**$113.95**
Language	**$95.90**
Speech & Language	**$127.41**
Voice	**$102.78**

Totals before any MPPR reduction; actual payment varies by locality and conversion factor.

Source: ASHA / CMS CY 2027 MPFS Proposed Rule (CMS-1848-P).

How MPPR works with timed codes

Billing several timed units or codes in one day triggers Medicare's Multiple Procedure Payment Reduction (MPPR), which trims the practice-expense portion of every therapy service after the first.

How the reduction works

- **It touches practice expense only —** the PE portion is roughly 45% of a code's value.
- **Highest-PE service is paid in full —** Medicare ranks the day's services and pays the top one at 100%.
- **Work and malpractice stay whole —** only PE is cut; your clinical work is never reduced.

What stacking codes means

- **The new codes stack —** a base plus add-ons, and a separate base for each domain you treat.
- **Extra units are "subsequent" —** so their PE could be halved, even within one discipline.
- **It pools across therapies —** same-day PT, OT, and SLP services are ranked together (within the same facility).

The same-day math

HIGHEST-PE SERVICE
Full 100% practice expense

EACH LATER SERVICE
Practice expense cut to 50%

WORK & MALPRACTICE
Always paid in full

Source: CMS Therapy Services / MPPR (50% PE reduction, effective April 1, 2013)

The proposed pediatric G code (GSLPP)

PROPOSED HCPCS G CODE

GSLPP

Untimed
pediatric speech-language pathology code

Created by CMS through Medicare rulemaking, outside the AMA CPT process, and not anticipated from prior AMA discussions.

What it means

Why CMS proposed it

It responds to the volume of concerns that the 10 timed codes may not represent pediatric sessions.

Medicare Part B only

As a Medicare G code, it would not automatically reach commercial or Medicaid patients (where most pediatric care is provided).

Proposed, not final

It could change or disappear in the final rule. Plan around the 10 timed codes, not around GSLPP.

Proposed RVUs and payment for GSLPP

EST. NATIONAL PAYMENT

$66.34

COMPARED TO 92507

2.28 total RVU · $76.15 (2026)—about $9.81 less per untimed session under GSLPP.

Maybe this works better for your practice if you typically offer 30 minute sessions

Proposed GSLPP values, built from the same three components

Proposed work RVU (skill / clinician effort)	**1.30**
Proposed practice expense (PE) RVU	**0.10**
Proposed malpractice (MP) RVU	**0.01**
Proposed total RVUs	**2.02**

≈ $66.34 estimated national Medicare payment for GSLPP. *GSLPP is proposed, untimed, and Medicare Part B only; values are not final until the CY 2027 final rule. Actual payment varies by locality (GPCI) and the annual conversion factor.*

STILL UNKNOWN

What we don't know yet

NCCI edits, code pairing/bundling rules for 2027— expected Nov-Dec 2026

The National Correct Coding Initiative edits will tell us which of the new codes can be billed together and which cannot. Until they publish, code pairing rules are unconfirmed. This will help answer questions such as whether 92609, feeding/swallowing codes, and multiple treatment codes can be reported together. For any comments regarding NCCI edits, email: NCCIPTPMUE@cms.hhs.gov

Medicaid and private payer adoption

Whether Medicaid and commercial payers adopt the new codes at all (and on what timeline) is still open. Adoption may vary payer by payer.

WSLHA is on it

WSLHA is working hard to make direct contact with Washington state payers ahead of the change, to support the transition and get members accurate information about each payer's process and adoption timeline.

We'll share updates with members as soon as we have them.

Timed codes: benefits and concerns

Time-based reporting ties payment to the care actually delivered and is broadly considered a fairer model than one flat code, but one that asks more of your documentation and billing.

Why timed codes help

- **Payment tracks real time —** longer, more intensive sessions are paid for the minutes delivered, not a flat fee, giving flexibility for longer sessions.
- **Clinical complexity shows —** a separate base code per domain captures multi-domain care that 92507 flattened.
- **Defensible billing —** minute-based records tie each claim directly to the care you provided and encourages more direct care.

What to watch for

- **More to document —** you must record and justify the minutes spent in each domain, session by session.
- **Stacked units could lose PE —** MPPR trims the practice expense on every service after the highest-paid one.
- **Less streamlined claims processing/higher error possibility—** will require more complex unit calculations, creating a greater number of places for errors to occur for both provider and payer.

The bottom line

THE UPSIDE

Pay tracks real treatment time and patient complexity

THE TRADE-OFF

More tracking & documentation, possible MPPR cuts

THE TAKEAWAY

These changes have nuanced implications with both positives and challenges

Source: ASHA / CMS CY 2027 MPFS Proposed Rule (CMS-1848-P)

How to comment to CMS

COMMENT DEADLINE

September 14, 2026 by 5p EST

60-day period
Final rule: Fall 2026

1 Go to Regulations.gov

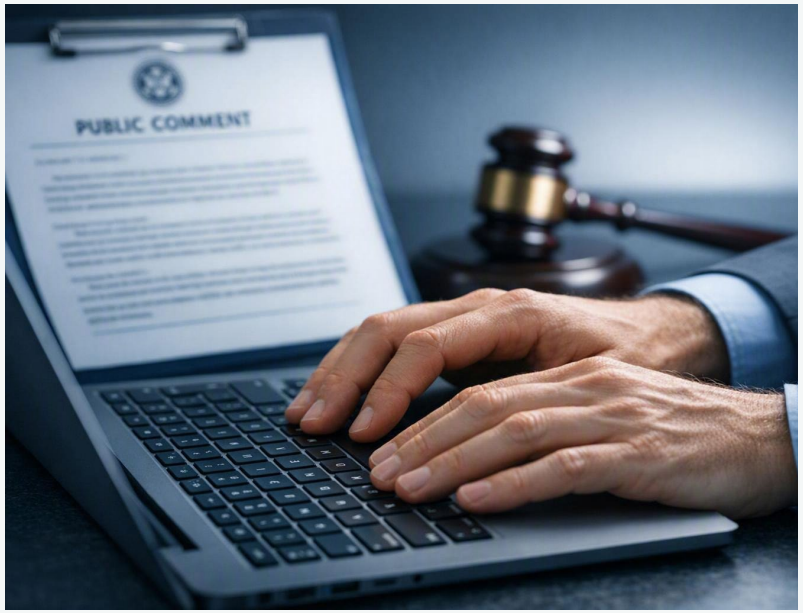
Open docket CMS-2026-2377 — or the Federal Register rule page and choose "Submit a public comment."

2 Reference the file code

In your comment, refer to file code CMS-1848-P so it is logged against the correct rule.

3 Write a specific comment

Identify as an individual or organization. Speak to the SLP codes, proposed RVUs, and the GSLPP pediatric code; you may attach supporting files.



SUBMIT ONLINE

regulations.gov/commenton/CMS-2026-2377-0002

File code: CMS-1848-P

What CMS can and can't address

CMS controls only part of this rule. Aim your comment at what the agency can actually change in the CY 2027 final rule — comments on everything else won't move the outcome.

What CMS can address

- **Practice expense and malpractice values —** how the 10 new codes are valued for PE and MP (the work RVU is set through the RUC process, and is unlikely to be changed by CMS given that they adopted the recommendations).
- **Whether GSLPP is finalized —** if the proposed untimed pediatric G code moves forward, and how it interacts with the 10 timed codes.
- **Telehealth listing —** whether the new codes are added to the Medicare Telehealth Services List.
- **Coding and claim guidance —** specific billing, unit, and documentation guidance issued before January 1, 2027.

What CMS can't address

- **Keeping 92507 —** deletion of the code came through the AMA CPT process, not Medicare rulemaking.
- **MPPR —** the multiple procedure payment reduction is long-standing policy outside this rule.
- **The work RVUs —** work values are recommended through the RUC/HCPAC process; CMS accepted them as recommended.

Where to aim

IN SCOPE

PE and MP values, GSLPP, telehealth listing, CMS guidance

OUT OF SCOPE

Restoring 92507, MPPR policy, the work RVUs

THE TAKEAWAY

A comment aimed at what CMS controls is a comment CMS can act on

Source: ASHA / CMS CY 2027 MPFS Proposed Rule (CMS-1848-P)

What to comment to CMS

Comment on the policy, not the frustration. Be specific, cite the rule, and keep each point to one issue.

Make it land

- Focus on the policy, not on frustration.
- Assume good faith on the part of CMS.
- Be specific and cite the rule you mean.
- Keep each comment to one issue.
- Collect data on YOUR practice expenses and how these updates meet or don't meet your expenses
- **Keep in mind that your comments go on the public record.**

Steer clear of

- Debating session timing or fine minutiae.
- Framing it as "I should be paid more."
- Conflating RVUs with take-home pay.
- The conversion factor is fee-schedule-wide, not SLP-specific. EVERY profession is experienced reductions due to a reduced conversion factor.

GSLPP considerations

- Pediatric care is not less complex than adult care.
- What does a realistic session look like when you breakdown pre/post time + client time
- Ask CMS to clarify how GSLPP interacts with the 10 codes.
- Flag the billing confusion and audit risk it could create.
- Will it cause overutilization flags again?

Structure a comment CMS will take seriously

1 Identify yourself and your role

2 Name the code or policy at issue

3 Share your clinical evidence

4 Explain the impact on patients

5 Recommend a specific change

6 Confirm figures and the deadline in the published rule

There is no template because this should be specific to you, your data/experience and your practice needs!

PUT IT TOGETHER

Structure a comment CMS will take seriously

Use the same six-part structure for every issue you raise. Quality matters far more than quantity — one well-built, well-evidenced comment carries more weight than a long list of grievances.

The six-part structure

- **1 Identify yourself and your role —** name your credential, setting, and the patients you serve.
- **2 Name the code or policy at issue —** cite file code CMS-1848-P and the specific code or provision.
- **3 Share your clinical evidence —** use your own session data, caseload, and practice expenses.
- **4 Explain the impact on patients —** describe access, frequency, and outcomes in concrete terms.
- **5 Recommend a specific change —** tell CMS exactly what you want done differently.
- **6 Confirm figures and the deadline —** verify every number against the published rule.

Make it count

- **Quality matters more than quantity —** one specific, evidence-backed comment outweighs a long list of general complaints.
- **Repeat the format for each issue —** run the full six steps separately for every issue you raise, one issue per comment.
- **Cover both the codes and GSLPP —** for your chosen issue, spell out the implications for the 10 new timed codes AND for the proposed pediatric G code.

Before you submit

ONE ISSUE

Each comment covers a single issue, start to finish

BOTH TRACKS

Address the 10 new codes and GSLPP for that issue

THE DEADLINE

September 14, 2026 at 5:00p EST, docket CMS-2026-2377

Source: ASHA / CMS CY 2027 MPFS Proposed Rule (CMS-1848-P)

How to prepare for the change

Business preparation

- **Review and update insurer contracts —** get a current copy of your contract with every contracted insurer.
- **Evaluate business policies —** review cancellation, no-show, and late policies; implement and enforce them if not already in place.
- **Communicate with your team —** plan how you'll brief front office, billing, and administrators on the code changes.
- **Monitor payer adoption timelines —** WSLHA is contacting local insurers; watch for when commercial payers beyond Medicare adopt the new codes.
- **Update billing and documentation systems —** coordinate with your EHR/billing platform so the new timed codes and domain-based documentation templates are ready.

Clinical planning

- **Identify the domains you're targeting —** just as you already choose an evaluation code, start attending to which domains you address in each session.
- **Align domains with SMART goals —** confirm each session's domains connect back to the client's treatment plan and SMART goals.
- **Roughly track minutes per domain —** get a general sense of the minutes spent on each domain to build comfort with the timed structure.

KEY TAKEAWAYS

The bottom line for SLPs

92507 today

Its 1.30 RVU is skill/effort only; with PE and MP the total is 2.28 RVUs (≈ $76.15).

Big change in 2027

92507 is deleted Jan 1, 2027 and replaced by 10 time-based codes (5 base + 5 add-on).

CMS's proposal

CMS accepted the RUC work RVUs and PE inputs without changes; values are proposed, not final.

New pediatric G code

GSLPP is an untimed, Part B-only proposal. It is ***not*** final and not automatic for other payers.

Act by Sept 14, 2026

Comment at regulations.gov (docket CMS-2026-2377, file code CMS-1848-P).

Sources: *ASHA — "CMS Proposes Medicare Payment for New Speech-Language Pathology Treatment Codes" (July 2026); CMS CY 2027 MPFS Proposed Rule (CMS-1848-P).*

WHAT WSLHA IS DOING

Save the dates for two learning opportunities this fall

Webinar — Oct 6, 2026, 6:30 p.m.

An instructional session going in depth on billing and documentation under the new codes.

Workshop — Nov 3, 2026, 6:30 p.m.

A hands-on session applying the new codes to real cases.

Documentation worksheet

We'll provide a worksheet you can use to start mapping out how to document and bill under the new time-based codes.
Bring it with you to the November workshop.

Real case examples

Will include a variety of adult and pediatric cases, collected from participants ahead of the workshop.

Bring your questions

Submit your own cases and billing questions when you register. Details to follow.

Reviewed by a team

Every case is reviewed by our SLP team and a professional coder before the session.

Watch your email and wslha.org for registration links.