healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Speech-Language Pathology Treatment Services		
Policy Number:	PO-RE-179v1		
Effective Date:	01/01/2027	**Last Approval Date:**	10/19/2026

I. Policy Description

Effective January 1, 2027, CPT code 92507 is deleted and may no longer be reported for speech-language pathology treatment services. CPT 92507 is replaced by 10 time-based CPT codes that more specifically identify the type of speech-language pathology treatment provided.

For dates of service on or after January 1, 2027, providers must report the applicable replacement CPT code(s) based on the treatment performed. The replacement codes consist of five treatment categories, with a primary code for the initial 30 minutes of direct, one-on-one treatment and a corresponding add-on code for each additional 15 minutes.

For dates of service through December 31, 2026, providers should continue to report CPT 92507 when appropriate.

The replacement of CPT 92507 with multiple treatment codes does not change Healthfirst's visit-based approach to authorization of speech therapy services. Providers should follow the authorization requirements described in this policy.

The information below applies to the following lines of business:

• Child Health Plus (CHP)	• Essential Plan (EP)
• Medicaid Managed Care (MMC)	• Managed Long Term Care Plan (MLTCP – Senior Health Partners)
• Medicare Advantage HMO	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicare PPO	• Qualified Health Plan (QHP)
• Personal Wellness Plan (HARP)	

Policy Scope

This policy applies to outpatient individual speech-language pathology treatment services provided to Healthfirst members.

This policy establishes reimbursement and billing requirements associated with the deletion of CPT 92507 and the use of its replacement CPT codes for dates of service beginning January 1, 2027.

The policy addresses:

- selection of the appropriate replacement CPT code based on the treatment provided;
- billing of initial and additional treatment time;
- applicable code combination and same-day billing requirements; prior authorization requirements for speech therapy treatment service and;
- documentation requirements supporting the services and units reported.

Coverage and reimbursement are subject to the member's benefits, applicable authorization requirements, provider participation agreement, Healthfirst reimbursement policies, and applicable federal and state requirements.

Reimbursement Guidelines

Deletion of CPT 92507

CPT 92507 is deleted effective January 1, 2027.

Providers must use the CPT code set applicable to the date of service.

Date of Service	Billing Requirement
Through December 31, 2026	Report CPT 92507 when appropriate.
January 1, 2027, and after	Do not report CPT 92507. Report the applicable replacement CPT code(s) based on the treatment performed.

Claims submitted with CPT 92507 for dates of service on or after January 1, 2027, may be denied or otherwise processed in accordance with applicable claims-editing requirements.

Replacement CPT Codes

For dates of service beginning January 1, 2027, providers must select the replacement CPT code that accurately represents the treatment performed and documented.

Treatment Category	Initial 30 Minutes	Each Additional 15 Minutes
Fluency disorder	92654	+92655
Speech sound production disorder	92656	+92657
Language disorder	92658	+92659
Combined speech sound production and language disorder	92660	+92661

Treatment Category	Initial 30 Minutes	Each Additional 15 Minutes
Voice, upper airway, and/or resonance disorder	92662	+92663

The primary codes represent the initial 30 minutes of treatment. The corresponding add-on codes represent additional 15-minute increments of treatment and must be reported in accordance with applicable CPT coding requirements**.**

Billing and Coding Guidelines

Providers must report the CPT code that most accurately represents the speech-language pathology treatment furnished and documented during the encounter.

- **Fluency Disorder — CPT 92654 and +92655**
  - Report **CPT 92654** for the initial 30 minutes of direct, one-on-one treatment of a fluency disorder, such as stuttering or cluttering.
  - Report **+92655**, when applicable, for each additional 15 minutes of treatment.
  - The add-on code must be reported in conjunction with the corresponding primary code and may not be reported as a stand-alone service.

  Do not report CPT 92654 or +92655 in conjunction with CPT 97153 or 97155

- **Speech Sound Production Disorder — CPT 92656 and +92657**
  - Report **CPT 92656** for the initial 30 minutes of direct, one-on-one treatment of a speech sound production disorder, such as articulation or phonological disorders, apraxia, or dysarthria.
  - Report **+92657**, when applicable, for each additional 15 minutes of treatment.

  Use +92657 in conjunction with CPT 92656. Do not report CPT 92656 or +92657 in conjunction with CPT 92658, +92659, 92660, +92661, 97153, or 97155.

- **Language Disorder — CPT 92658 and +92659**
  - Report **CPT 92658** for the initial 30 minutes of direct, one-on-one treatment of a language disorder, such as receptive, expressive, or pragmatic language disorders.
  - Report **+92659**, when applicable, for each additional 15 minutes of treatment.
  - When both a language disorder and speech sound production disorder are treated during the same encounter, providers should report the applicable combined treatment code.

  Use +92659 in conjunction with CPT 92658. Do not report CPT 92658 or +92659 in conjunction with CPT 92656, +92657, 92660, +92661, 97153, or 97155.

- **Combined Speech Sound Production and Language Disorder — CPT 92660 and +92661**
  - When treatment addresses both a speech sound production disorder and a language disorder during the same encounter, report **CPT 92660** for the initial 30 minutes.
  - Report **+92661**, when applicable, for each additional 15 minutes.

- Providers should not separately report the individual speech sound production and language treatment code families when the combined treatment code appropriately describes the services performed.

Use +92661 in conjunction with CPT 92660. Do not report CPT 92660 or +92661 in conjunction with CPT 92656, +92657, 92658, +92659, 97153, or 97155.

- **Voice, Upper Airway, and/or Resonance Disorder — CPT 92662 and +92663**
  - Report **CPT 92662** for the initial 30 minutes of direct, one-on-one treatment of a voice, upper airway dysfunction, and/or resonance disorder.
  - Report **+92663**, when applicable, for each additional 15 minutes of treatment.
  - The add-on code must be reported with the corresponding primary code.

Do not report CPT 92662 or +92663 in conjunction with CPT 97153 or 97155.

- **Time-Based Billing Guidelines**
  - The replacement CPT codes are time-based. Documentation must support the treatment time reported on the claim.
  - The primary code represents the **initial 30 minutes** of direct, one-on-one treatment. The corresponding add-on code represents **each additional 15 minutes** of qualifying treatment.
  - Add-on codes:
    - must be reported with the corresponding primary code;
    - may not be reported as stand-alone services;
    - must represent qualifying additional treatment time; and
    - must be supported by documentation of the duration and treatment furnished.

Providers must follow applicable CPT coding conventions when determining whether documented treatment time supports reporting an additional unit.

- **Code Combination Guidelines**
  - Providers must select the code family that most accurately reflects the treatment performed during the encounter.
  - When both speech sound production and language disorders are treated during the same encounter, providers should report the applicable **combined treatment code family, CPT 92660 and +92661**, rather than separately reporting the speech sound production and language code families.
  - Providers should not separately report services when CPT coding instructions identify the services as mutually exclusive or otherwise prohibit the code combination.
  - Claims may be subject to coding edits when reported code combinations are inconsistent with applicable CPT coding requirements or Healthfirst reimbursement requirements.

- **Group Treatment**
  - **CPT 92508** remains applicable to qualifying group speech-language pathology treatment and **is not replaced by the new individual treatment codes**.
  - Providers should report CPT 92508 when applicable requirements for group treatment are met. CPT 92508 should not be reported as a substitute for deleted CPT 92507 when individual treatment is provided.

Prior Authorization Guidelines

Speech therapy treatment services are subject to applicable Healthfirst prior authorization requirements. Evaluations and reevaluations do not require prior authorization. An approved prior authorization must be on file before Speech Therapy treatment services begin.

For Healthfirst prior authorization purposes, CPT code 92508 will be used to represent all speech therapy services performed on the same date. Healthfirst does not authorize individual modalities or treatment codes. Providers will receive authorization for a specified number of visits.

How to Submit a Prior Authorization Request

Providers are strongly encouraged to submit requests through the **Healthfirst Provider Portal at hfproviderportal.org**:

- Log in to the Healthfirst Provider Portal.
- Select **Online Authorization**.
- Select **Authorization Request** from the dropdown menu.
- Select **Begin** to initiate the request.
- Under **Procedure Information**, select the appropriate Speech Therapy service type. **CPT code 92508 will default as the authorization code.**
- Select the correct servicing location and NPI. The servicing location must reflect where the member will receive treatment.

Important Prior Authorization Information

- **Evaluations and reevaluations do not require prior authorization.**
- An **approved prior authorization must be on file before Speech Therapy treatment services begin**.
- There is no specified timeframe for submitting a prior authorization request; however, authorization must be approved before treatment begins.
- Prior authorization requests may also be submitted by fax; however, use of the Healthfirst Provider Portal is **strongly encouraged**.
- Authorization status can be viewed through **My Requests** or **Authorization Search** within the Online Authorization tool.
- If a patient has an existing authorization containing deleted CPT code **92507**, contact **Healthfirst Provider Services at 1-888-801-1660** for assistance before submitting a new request.

Need help setting up a Provider Portal account? Review the Healthfirst Provider Portal Account Creation Guide or contact your Network Account Manager.

Documentation Requirements

The medical record must support the CPT code and units reported on the claim.

Documentation should include, as applicable:

- the speech-language disorder or functional deficit being treated;
- the skilled treatment or intervention performed;
- treatment goals addressed during the encounter;
- direct treatment time;
- the patient's response to treatment and progress toward established goals; and
- the rendering provider's required authentication.

When an additional 15-minute add-on code is reported, documentation must support the additional treatment time.

Healthfirst may request medical records or other documentation to validate appropriate coding and reimbursement.

Adjudication and Appeal Process

1. Reimbursement is subject to the member's benefits, applicable authorization requirements, provider agreement, Healthfirst fee schedule and reimbursement methodology, and applicable coding and claims-editing requirements.

2. Use of a CPT code does not guarantee reimbursement. Services must meet applicable coverage, coding, documentation, and authorization requirements.

3. Incorrect coding, reporting unsupported units, billing an add-on code without its required primary code, or reporting prohibited code combinations may result in claim denial, adjustment, or recovery of an overpayment, as applicable.

4. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.

5. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

6. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

II. Applicable Codes

Code	Description	Comment
92654	Treatment of fluency disorder; direct one-on-one patient contact; initial 30 minutes.	Primary code
92655	Fluency disorder treatment; each additional 15 minutes.	Add-on to 92654
92656	Treatment of speech sound production disorder; direct one-on-one patient contact; initial 30 minutes.	Primary code
92657	Speech sound production disorder treatment; each additional 15 minutes.	Add-on to 92656
92658	Treatment of language comprehension and expression disorder; direct one-on-one patient contact; initial 30 minutes	Primary code
92659	Language comprehension and expression disorder treatment; each additional 15 minutes.	Add-on to 92658
92660	Treatment of speech sound production and language comprehension and expression disorders; direct one-on-one patient contact; initial 30 minutes.	Primary code
92661	Combined speech sound production and language treatment; each additional 15 minutes.	Add-on to 92660
92662	Treatment of voice, upper airway dysfunction, and/or resonance disorders; direct one-on-one patient contact; initial 30 minutes.	Primary code
92663	Voice, upper airway dysfunction, and/or resonance disorder treatment;	Add-on to 92662

	each additional 15 minutes.	
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Group Treatment

III. Definitions

Term	Meaning
Add-on Code	A CPT code that describes additional time or services associated with a primary procedure. An add-on code must be reported with the applicable primary CPT code and may not be reported as a stand-alone service.
Direct (One-on-One) Patient Contact	Treatment provided directly by the qualified treating provider to one patient. The replacement CPT codes addressed in this policy describe individual treatment involving direct one-on-one patient contact.
Primary Code	The CPT code used to report the initial treatment service. For the replacement codes addressed in this policy, the primary code represents the initial 30 minutes of the applicable direct one-on-one treatment.
Time-Based Code	A CPT code for which reporting is based on the amount of qualifying treatment time provided and documented. The medical record must support the time associated with the code and units reported.

IV. Related Policies

Policy Number	Policy Description
MP-085	Outpatient Rehabilitation Therapies

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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

American Speech-Language-Hearing Association (ASHA). *Update on CPT Code 92507: Valuation*

Review Underway.
American Speech-Language-Hearing Association (ASHA). *New Speech-Language Pathology Treatment Codes Replacing 92507.*
Speech-Language Pathology Treatment Codes Replacing 92507
Availity Essentials - Sign In
Centers for Medicare & Medicaid Services. Applicable Medicare Physician Fee Schedule and coding guidance.

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.