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DEDICATED TO THE HEALTH OF ALL CHILDREN™

Hearing-Related Services Coding Fact Sheet

While coding for hearing screening is relatively straightforward, ensuring that appropriate payment is received for such services is a more complicated matter. This Coding Fact Sheet will provide you with a guide to coding for pediatric hearing screening. While we have provided you with some suggested codes, it should be noted that payer recognition of codes might vary. Most plans are required to cover hearing screen services under the Affordable Care Act, however, that may still vary. The codes listed here are commonly reported not an exhaustive list.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes

Hearing Loss

ICD-10-CM
H90.0 Conductive hearing loss, bilateral **H90.11** Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; right ear **H90.12** left ear **H90.2** Conductive hearing loss, unspecified **H90.A11** Conductive hearing loss, unilateral, right ear with restricted hearing on thecontralateral side **H90.A12** Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateralside
H90.3 Sensorineural hearing loss, bilateral **H90.41** Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateralside **H90.42** Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateralside **H90.5** Unspecified sensorineural hearing loss **H90.A21** Sensorineural hearing loss, unilateral, right ear, with restricted hearing on thecontralateral side **H90.A22** Sensorineural hearing loss, unilateral, left ear, with restricted hearing on thecontralateral side
H90.6 Mixed conductive and sensorineural hearing loss, bilateral **H90.71** Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side **H90.72** Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side **H90.8** Mixed conductive and sensorineural hearing loss, unspecified **H90.A31** Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side **H90.A32** Mixed conductive and sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side
H91.9- Unspecified hearing loss For 5th digit use 1= Right ear; 2=Left ear; 3=Bilateral

Other Diagnosis Codes Related To Hearing Loss

H60.31- Diffuse otitis externa **H60.39-** Other infective otitis externa For 6th digit use 1=Right ear; 2=Left ear; 3=Bilateral
H60.33- Swimmer's ear For 6th digit use 1=Right ear; 2=Left ear; 3=Bilateral
H61.2- Impacted cerumen For 5th digit use 1= Right ear; 2=Left ear; 3=Bilateral
H65.2- Chronic serous otitis media For 5th digit use 1= Right ear; 2=Left ear; 3=Bilateral
H65.49- Other chronic nonsuppurative otitis media For 6th digit use 1=Right ear; 2=Left ear; 3=Bilateral
H65.9- Unspecified nonsuppurative otitis media For 5th digit use 1= Right ear; 2=Left ear; 3=Bilateral
H66.00- Acute suppurative otitis media without spontaneous rupture of ear drum For 6th digit use 1= Right ear; 2=Left ear; 3=Bilateral; 4=Recurrent right ear; 5=Recurrent left ear; 6=Recurrent bilateral
H66.01- Acute suppurative otitis media with spontaneous rupture of ear drum For 6th digit use 1= Right ear; 2=Left ear; 3=Bilateral; 4=Recurrent right ear; 5=Recurrent left ear; 6=Recurrent bilateral
H66.3X- Other chronic suppurative otitis media For 6th digit use 1=Right ear; 2=Left ear; 3=Bilateral
H69.8- Other specified disorders of Eustachian tube **H69.9-** Unspecified Eustachian tube disorder For 5th digit use 1= Right ear; 2=Left ear; 3=Bilateral
H73.01- Bullous myringitis For 6th digit use 1=Right ear; 2=Left ear; 3=Bilateral
H72.9- Unspecified perforation of tympanic membrane For 5th digit use 1= Right ear; 2=Left ear; 3=Bilateral
H83.0- Labyrinthitis For 5th digit use 1=Right ear; 2=Left ear; 3=Bilateral; 9=Unspecified
H92.0- Otalgia For 5th digit use 1=Right ear; 2=Left ear; 3=Bilateral

H92.1- Otorrhea

For 5th digit use 1= Right ear; 2=Left ear; 3=Bilateral

H93.1- Tinnitus

For 5th digit use 1=Right ear; 2=Left ear; 3=Bilateral; 9=Unspecified

H93.8X- Other specified disorders of ear

For 6th digit use 1=Right ear; 2=Left ear; 3=Bilateral; 9=Unspecified

CONGENITAL ANOMALIES

Q16.0 Congenital absence of (ear) auricle

Q16.1 Congenital absence, atresia and stricture of auditory canal (external)

Q16.2 Absence of eustachian tube

Q16.3 Congenital malformation of ear ossicles

Q16.4 Other congenital malformations of middle ear

Q16.5 Congenital malformation of inner ear
Q16.9 Congenital malformation of ear causing impairment of hearing, unspecified

Q17.2 Microtia

Q17.9 Congenital malformation of ear, unspecified (NOS)

INJURY AND POISONING

S09.21- Traumatic rupture of right ear drum

S09.22- Traumatic rupture of left ear drum

S09.91- Unspecified injury of ear

T16.1- Foreign body in right ear

T16.2- Foreign body in left ear

[Use additional code to identify if there is a retained FB (**Z18**-)]

T75.3- Motion sickness

[Use additional external cause code to identify vehicle or type of motion (**Y92.81-, Y93.5**-)]

For codes **S09**-, **T16**- and **T75**- a 7th character is required to define the encounter.

A= initial encounter; **D** = subsequent encounter; **S** =sequel (Note use placeholder X for 5th and/or 6th characters as necessary)

SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS

R42 Dizziness and giddiness/ Vertigo

R47.1 Dysarthria and anarthria

R47.89	Other speech disturbances
R49.0	Dysphonia
R49.21	Hypernasality
R49.22	Hyponasality
R49.8	Other voice and resonance disorders
R49.9	Unspecified voice and resonance disorder
R68.89	Other general symptoms and signs
P09.6	Abnormal findings on neonatal screening for neonatal hearing loss

Z CODES

Z codes represent reasons for encounters. Categories **Z00–Z99** are provided for occasions when circumstances other than a disease, injury, or external cause classifiable to categories **A00–Y89** are recorded as 'diagnoses' or 'problems'. This can arise in 2 main ways.

(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem is in itself not a disease or injury.

(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

(c) When a social determinant of health is identified during an encounter and it is either addressed or shown to complicate the encounter, it should be coded.

Z01.10	Encounter for examination of ears and hearing without abnormal findings **Z01.110** Encounter for hearing examination following failed hearing screening **Z01.118** Encounter for examination of ears and hearing with other abnormal findings [Use additional code to report abnormal findings]
Z60.8	Other problems related to social environment
Z65.9	Problem related to unspecified psychosocial circumstances
Z71.89	Other specified counseling
Z73.3	Stress, not elsewhere classified
Z78.9	Other specified health status
Z79.899	Other long term (current) drug therapy
Z82.2	Family history of deafness and hearing loss
Z86.61	Personal history of infections of the central nervous system
Z86.69	Personal history of other diseases of the nervous system and sense organs
Z97.4	Presence of external hearing-aid
Z98.89	Other specified postprocedural states

- Indicates an additional character is required. Refer to the *ICD-10-CM* Manual.

Current Procedural Terminology (CPT®) Codes

The audiometric tests listed below require the use of calibrated electronic equipment, recording of results, and a report with interpretation. Hearing tests (such as whispered voice, tuning fork) that are otorhinolaryngologic evaluation and management services are not reported separately. All services listed are bilateral. Use modifier 52 if a test is applied to one ear only.

92550	Tympanometry and reflex threshold measurements
92551	Screening test, pure tone, air only
92552 **92558**	Pure tone audiometry (threshold); air only Evoked otoacoustic emissions, *screening*, automated analysis
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing, threshold
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing and acoustic reflex decay testing (*Do not report with 92567, 92568*)
92583	Select picture audiometry
92587 **92588**	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 comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum 12 frequencies
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis
69200	Removal of foreign body from external auditory canal; without general anesthesia
69209	Removal impacted cerumen using irrigation/lavage, unilateral (For bilateral removal, use modifier **50**)
69210	Removal impacted cerumen requiring instrumentation, unilateral (For bilateral removal, use modifier **50**)
69420	Myringotomy including aspiration and/or eustachian tube inflation
69930	Cochlear device implantation, with or without mastoidectomy

Health and Behavior Assessment/Intervention Codes

These codes are not reported by a physician.

Assessment

96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)

The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and

treatments.

Intervention

96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
+96159	each additional 15 minutes (List separately in addition to code 96158)
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
+96165	each additional 15 minutes (List separately in addition to 96164)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
+96168	each additional 15 minutes (List separately in addition to 96167)
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
+96171	each additional 15 minutes (List separately in addition to 96170)

The focus of the intervention is to improve the patient's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate the specific hearing-related problems.

Healthcare Common Procedural Coding System (HCPCS) Codes

CPT codes are also known as Healthcare Common Procedure Coding System (HCPCS) Level I codes. The HCPCS also contains Level II codes. These Level II codes (commonly referred to as HCPCS "hick-picks" codes) are national codes that are included as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard procedural transaction coding set along with CPT codes.

HCPCS Level II codes were developed to fill in the gaps in the CPT nomenclature. While they are reported in the same way as a CPT code, they consist of one alphabetic character (A-V) followed by four digits. In the past, insurance carriers did not uniformly recognize HCPCS Level II codes. However, with the advent of HIPAA, carrier software systems must now be able to recognize all HCPCS Level I (CPT®) and Level II codes.

HCPCS Hearing Services Codes

S9445	Patient education, not otherwise classified, nonphysician provider, individual, per session
S9446	Patient education, not otherwise classified, nonphysician provider, group, per session
T1023	Screening to determine the appropriateness of consideration of an individual for participation in specified program, project, or treatment protocol, per encounter
T1027	Family training and counseling for child development, per 15 minutes
T1028	Assessment of home, physical, and family environment, to determine suitability to meet patient's medical needs
T2022	Case management, per month
T2023	Targeted case management, per month
T2024	Service assessment/plan of care development, waiver

V5008	Hearing screening
V5362	Speech screening
V5363	Language screening
V5364	Dysphagia screening

Modifiers

25 Significant and separately identifiable evaluation and management service

50 Bilateral procedure

52 Reduced procedural service (can be used when a code indicates a bilateral hearing screen/test, but only one ear is tested)

59 Distinct procedural service

Vignettes

Vignette #1

5-year-old male established patient presenting for pre-kindergarten health assessment, fails to pass the hearing screen, using a pure tone audiometer at the 30 decibels (dB) level from 500 to 4000 Hertz (Hz) in the left ear. He has a history of three ear infections in his second year. Tympanometry is normal for both ears, indicating no evidence of middle ear effusion. Parents deny any behaviors that would suggest hearing loss (does not turn up the TV, appears to hear voice commands, and does not speak loudly).

How is this service reported?

CPT Coding:

99393	Preventive medicine service, established patient; late childhood (age 5 through 11 years)
92551	Screening test, pure tone, air only
92567	Tympanometry (impedance testing)

ICD-10-CM Coding:

Z00.121 Encounter for routine child health examination with abnormal findings	Link to 99393 and 92551
H91.92 Unspecified hearing loss, left ear	Link to 92551 and 92567

Note: Contrary to CPT® guidelines, some payers may inappropriately bundle the screening audiometry service(s) with the preventive medicine evaluation and management (E/M) code. Appending modifier 25 to the preventive medicine service may unbundle the services.

Health assessment should include information pertinent to hearing loss such as prenatal or perinatal risk factors, family history of hearing loss under 30 years of age, physical stigmata related to hearing loss.

The patient is then referred to an audiologist proficient in hearing testing of children for diagnostic testing. Audiologist report for pure tone audiometry (air and bone) and sound booth testing indicates he has sensorineural hearing loss at 50dB in the left ear and normal hearing at 20 dB in the right ear; his left ear speech threshold is 40 dB and right ear speech threshold is 15 dB.

How is this service reported?

CPT Coding:

92553	Pure tone audiometry (threshold); air and bone
92555	Speech audiometry threshold

ICD-10-CM Coding:

H90.42	Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateralside	Link to **92553** and **92555**

Pediatrician counsels parents for 15 minutes on the audiological diagnostic testing results, reviews possible etiologies for unilateral hearing loss, provides information on the effects of unilateral hearing loss on classroom learning, and refers the patient to an otolaryngologist.

How is this service reported?

CPT Coding:

99213	Office or other outpatient visit, established patient (greater than 50 percent of visit spent counseling and code 99213 has a typical time of 15 minutes)

ICD-10-CM Coding:

H90.42	Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateralside	Link to **99213**

Note: Otolaryngologist may request CT of left ear or BAER (ABR) testing. Patient should be considered for unilateral amplification in the classroom setting to reduce possible learning barrier.

Vignette #2

An infant is born to parents who both have hearing loss greater than 90 dB. The newborn hearing screen is normal, with no indication of hearing loss. There is a significant family history of congenital hearing loss in both families. Patient is recommended by the hospital hearing screener for repeat hearing testing at 6 months.

How is this service reported?

CPT Coding:

92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)

ICD-10-CM Coding:

Z82.2	Family history of deafness and hearing loss	Link both to **92587**
Z01.10	Encounter for examination of ears and hearing without abnormal findings	

Note: Payers may inappropriately bundle this procedure into the hospital care E/M code.

Six months later, patient sees hospital screener for repeat hearing testing. Options might include automated brain response (auditory evoked potentials) versus sound booth testing as OAE testing not possible in the active child. Because of the family history, parents are

offered a referral to a geneticist for testing for the Connexin 26 gene and subsequent genetic counseling. Referral to an early intervention agency is provided so communication issues can be addressed as parents sign only and have no oral speech. How is this service reported?

CPT Coding:

92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis
92551	Screening test, pure tone only

ICD-10-CM Coding:

Z82.2 Family history of deafness and hearing loss **Z01.10** Encounter for examination of ears and hearing without abnormal findings	Link to **92650** or **92551**

Vignette #3

Physician sees patient to confirm audiological screening results. Recommends genetic assessment for Connexin gene for future pregnancy planning. Recommends family seek early intervention services to address communication issues for deaf parents who sign only and a hearing child. How is this service reported?

CPT Coding:

99213	Office or other outpatient visit, established patient, problem focused/low complexity

ICD-10-CM Coding:

Z31.5 Encounter for genetic counseling	Link to **99213**
Z82.2 Family history of deafness and hearing loss	Link to **99213**

Vignette #4

An infant who was referred following an abnormal otoacoustic emission hearing test also fails diagnostic testing at age 5 weeks for both OAE and ABR. ABR indicates a pure tone threshold at about 80dB in both ears; hearing aids may improve auditory acuity. The parents have normal hearing. How is this service reported?

CPT Coding:

92588	Evoked acoustic emissions, comprehensive or diagnostic testing
92652	Auditory evoked potentials, for threshold estimation at multiple frequencies, with interpretation and report

ICD-10-CM Coding:

H90.3 Sensorineural hearing loss, bilateral	Link to **92588** and **92652**

Vignette #5

Patient requires a medical workup for congenital hearing loss. History should assess prenatal or perinatal causes, family history of hearing loss, examination for stigmata associated with hearing loss, genetic testing, EKG (CPT code 93000), and ENT and ophthalmological exams. How is this service reported?

CPT Coding:

99215	Office or other outpatient visit, established patient, comprehensive/high complexity

ICD-10-CM Coding:

H90.3 Sensorineural hearing loss, bilateral	Link to **99215**

Vignette #6

At the 8-week well exam the parents inquire about the next steps to eventually obtaining a cochlear device so the patient can have oral communication. They want to know what is done during the waiting period for the cochlear implant to communicate effectively with their infant and whether there are any additional referrals to other physicians or studies needed. How is this service reported?

CPT Coding:

99391	Preventive medicine service, established patient; infant (age under 1 year)
9921X-25	Office or other outpatient visit, established patient (code level selected from 99212-99215 family depending on medical decision making or total time spent), appended with modifier **25**

ICD-10-CM Coding:

Z00.121 Encounter for routine child health examination with abnormal findings	Link to **99391**
Z71.89 Other specified counseling	Link to **9921X-25**
H90.3 Sensorineural hearing loss, bilateral	Link to **9921X-25**

Vignette #7

Patient needs referral to area cochlear implant service, early intervention agency to facilitate nonverbal communication pending cochlear implant by 3 months, and CT scan of ears to assess inner ear anatomy. Otolaryngologist and audiologist should refer patient for auditory amplification by age 6 months.

CPT Coding:

69930	Cochlear device implantation, with or without mastoidectomy

ICD-10-CM Coding:

H90.3 Sensorineural hearing loss, bilateral	Link to **69930**