Billing and Reimbursement Codes for Early Childhood Periodic Hearing Screening

The primary codes most often needed for billing and reimbursement purposes related to OAE and tympanometry screening are:

**Procedure code (CPT)**
- 92587 OAE Limited
- 92567 Tympanometry

**Commonly Used Diagnosis Codes (ICD-9)**
- 315.31 Delayed Speech and Language Development
- 315.34 Speech and Language Developmental Delay due to Hearing Loss
- 315.39 Articulation Errors
- 382.9 Unspecified otitis media
- 384.20 History of Tympanic Membrane Perforation, Perforation of the Tympanic Membrane, Unspecified
- 388.6 Discharging Ear Otorrhea, Unspecified
- 388.7 Ear Pain Otalgia, Unspecified
- 388.8 Aural Fullness, Other Disorders of the Ear
- **389.9 Unspecified Hearing Loss**
- 783.42 Delayed Milestones, Late Talker

**V72.11 Encounter for hearing examination following a previously failed hearing screening**

**V72.19 Examination of ears and hearing**

**Examples of Diagnosis Codes Used for Hearing Screening**

<table>
<thead>
<tr>
<th>Reason for Screening</th>
<th>Screening Outcome</th>
<th>Coding Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child receives OAE rescreen due to refer on previous screening</td>
<td>Refer on OAE</td>
<td>389.9</td>
</tr>
<tr>
<td></td>
<td>Pass OAE</td>
<td>389.9 V72.11</td>
</tr>
<tr>
<td>Child receives OAE screen in response to specific concern(s)</td>
<td>Refer on OAE</td>
<td>389.9</td>
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<tr>
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<td>Pass OAE</td>
<td>389.9</td>
</tr>
<tr>
<td>Child receives OAE screen as a routine part of well-child checkup; no specific concern(s)</td>
<td>Refer on OAE</td>
<td>389.9</td>
</tr>
<tr>
<td></td>
<td>Pass OAE</td>
<td>V72.19</td>
</tr>
</tbody>
</table>

Children who refer on OAE screening can typically be coded as 389.9—unspecified hearing loss—based on the following: “If the diagnosis documented at the time is qualified as ‘probable,’ ‘suspected’, ‘likely,’ ‘questionable,’ ‘possible,’ or ‘still to be ruled out,’ code the condition as if it existed or was established.”

As shown above, whenever possible, other ear, hearing and communication disorder diagnosis codes should be used before using a V code. Children with high-risk factors can be coded on that basis. In these cases, the signs and symptoms, chief complaint, or reason(s) for the encounter should be reported as the primary diagnosis. The provider can also use additional codes that describe any coexisting or chronic conditions. (Do not code conditions previously treated that no longer exist – although history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.) Medicaid and most private insurance providers will cover one hearing screening annually.