Demystifying CPT Code 92700

By Brandy Stephens

There are Current Procedural Terminology (CPT) codes for almost every audiology procedure that exists. It is important to use the code that most accurately represents the audiologic procedure or service provided, which is often very straightforward.

According to the American Medical Association (2018), providers should "[s]elect the name of the procedure or service that accurately identifies the service provided. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code."

In audiology, we have several clinically relevant procedures that do not have unique CPT codes. For these services, there is an unspecified code—92700-unlisted otorhinolaryngological procedure—that providers may consider to code distinct procedures not included in other CPT codes. The use of 92700 should not be chosen solely for higher reimbursement. If a CPT code exists for a procedure, that specific code should be used.

Before billing unlisted codes, providers should review payer guidelines and follow payer policies for notice of noncoverage if an unlisted code is not covered. In the event of noncoverage, providers should review their payer contracts to determine if patients can be billed for the service. In addition, providers may consult with their Medicare Administrative Contractor (MAC) on required documentation when setting up billing and documentation protocols for unlisted codes.

It is important for audiologists to become familiar with CPT code 92700 because submitting this code for billing and reimbursement purposes requires an understanding of associated reporting requirements. TABLE 1 lists some common procedures and services that are most appropriately coded using 92700.

Most often, in audiology practices, 92700 is used for bone-anchored implant (BAI) services and follow-up visits, vestibular-evoked myogenic potential (VEMP) testing, and tinnitus treatment. Because there is not a specific CPT code that describes the services listed above, the clinician may use 92700 for billing.

Since 92700 is an unspecified code and can be used to code/bill several services, the provider must document additional information for the insurance company to understand

TABLE 1: Common Uses of 92700 in audiology practices include, but are not limited to, the following:

VESTIBULAR-EVOKED MYOGENIC POTENTIAL (VEMP) TESTING
According to Academy of Doctors of Audiology (ADA), American Academy of Audiology (AAA), and the American Speech-Language-Hearing Association (ASHA) collaborative guidance: "It is also important to read and review your Medicaid and third-party payer contracts to determine if VEMPs are a covered procedure. State Medicaid programs may have specific coding and coverage guidance unique to the performance of VEMPs in a particular state."
BONE-ANCHORED IMPLANT FITTING AND CLINICAL SERVICES
According to Oticon Medical Group (August 2018) and Cochlear Corporation (August 2018) billing and coding guidance, some payers may incorrectly specify a bone-anchored device as a hearing aid and therefore may require the use of hearing aid codes for these services. Providers should consult with payers before billing bone-anchored services.
SPEECH-IN-NOISE TESTING
According to ADA, AAA, and ASHA collaborative guidance: "Speech-in-noise testing could be included in comprehensive audiological evaluation (92557) or as part of speech audiometry with speech recognition (92556) evaluation. Alternatively, it could be billed as an unlisted otorhinolaryngological procedure code 92700, with documentation and explanation of the procedure. Audiologists should consult payer guidelines for submitting the unlisted code. CPT code 92700 should not be filed to Medicare if used as a predictor of hearing aid performance in noise (when code 92626 is not appropriate, such as unaided testing)."
TINNITUS MANAGEMENT AND TREATMENT (FOR SERVICES NOT INCLUDED IN CPT 92625)
SACCADE TESTING (SATTERFIELD AND SWANSON, 2015)

what is being billed. When using this code, audiologists must provide the insurer with the name of the test or service, along with the following documentation (Satterfield and Swanson, 2015, 2016):

- A copy of the patient report and results
- Description of the nature, extent, and need for the procedure including but not limited to:
  - Details of the procedure performed along with the required effort of the procedure.
  - The clinical utility of the procedure. This includes the information gained from the procedure, or the purpose of the procedure. What differential diagnosis is offered by the procedure? Why was this procedure chosen? Documentation may state why patients present for this testing or procedure and how this will help lead to a resolution of the problem.
  - Amount of time required for the procedure.
  - Skills/qualifications of the individual performing the procedure.
  - Equipment and supplies used for the procedure. This can be the specific or general test equipment used for testing.
  - Documents that the procedure is an independent procedure.

This may seem like a lot of information to provide for every patient, however it is common to have templated documentation that can be used for billing all instances of the same procedure. If frequently billing for VEMPs, for example, to save time the provider would have a separate document with the necessary information, or a note template already written within the EMR system to save time.

In addition, since 92700 may be used for multiple procedures that likely differ in cost, each clinic should develop a charge master with associated fees. The clinician should be careful to indicate the appropriate cost for that use of 92700. For example, the fee for conducting a VEMP will likely differ from a BAI fitting fee. Last, providers should not submit multiple units on the same day or use modifiers with 92700 (Satterfield and Swanson, 2015).

Once a system is in place for using CPT code 92700, it can be relatively straightforward to use. This code will provide a method for submitting charges to payers and/or patients to be reimbursed for procedures and services that cannot otherwise be coded.

For more information regarding coding and reimbursement, see the coding page on the American Academy of Audiology website at www.audiology.org/practice_management/coding/coding

Brandy Stephens, AuD, is a pediatric audiologist at Vanderbilt University Medical Center in Nashville, Tennessee. Stephens is the lead clinician responsible for the Bone-Anchored Hearing Instrument Program, providing services in the Vanderbilt Microtia/Atresia Clinic. She serves on the Academy's Coding and Reimbursement Committee.

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