Hearing Device Services Codes: Frequently Asked Questions

The new "Hearing Device Services Codes" are listed in the CPT® manual as "Evaluative and Therapeutic Services." Audiologists are most familiar with diagnostic codes in the "Audiologic Function Tests" section, which specifically define which tests must be included when providing the stated service. The codes included in the "Evaluative and Therapeutic Services" section provide greater flexibility for the provider in choice of assessment measures and allow for clinical decision making and treatment/management appropriate for the encounter.

General Questions

Q: Why do we need new hearing aid codes?

A: The current CPT hearing device services codes are inadequate in their description and do not represent the breadth of contemporary audiology treatment services. With the evolution from analog to digital technology, the current codes are not representative of the technological advances that have occurred since the original codes were created. With modern technology, there is much greater capacity for adjustment and feature manipulation, expanded candidacy criteria, and much greater clinical use of real-ear measurement and other verification protocols.

Q: What CPT hearing aid codes are being replaced?

A: The legacy codes—CPT 92590 through 92595— which have been in place since 1993.

92590 - Hearing aid examination and selection; monaural

92591 - Hearing aid examination and selection; binaural

92592 - Hearing aid check; monaural

92593 - Hearing aid check; binaural

92594 - Electroacoustic evaluation for hearing aid; monaural

92595 - Electroacoustic evaluation for hearing aid; binaural

Q: What do the new codes cover?

A: Effective January 1, 2026, audiologists will have a new set of 12 CPT codes to describe the range and intensity of hearing aid device services they provide. The new code set captures six key components of care: candidacy, device selection, fitting, post-fitting follow-up, verification and hearing assistive supplemental device fitting.

Q: What are the new codes?

A:

CPT Code	CPT Long Descriptor
92628	Evaluation for hearing aid candidacy, unilateral or bilateral, including review and integration of audiologic function tests, assessment, and interpretation of hearing needs (eg, speech-in-noise, suprathreshold hearing measures), discussion of candidacy results, counseling on treatment options with report, and, when performed, assessment of cognitive and communication status; first 30 minutes (Do not report 92628 in conjunction with 92631, 92632, 92636, 92637, 92642) (Do not report 92628 in conjunction with 92622, 92623, 92626, 92627, if performed on the same ear) (For hearing testing, see 92550-92588)
+92629	each additional 15 minutes (List separately in addition to code for primary procedure) (Use 92629 in conjunction with 92628)
92631	Hearing aid selection services, unilateral or bilateral, including review of audiologic function tests and hearing aid candidacy evaluation, assessment of visual and dexterity limitations, and psychosocial factors, establishment of device type, output requirements, signal processing strategies and additional features, discussion of device recommendations with report; first 30 minutes (Do not report 92631 in conjunction with 92628, 92629, 92636, 92637, 92642) (Do not report 92631 in conjunction with 92622, 92623, 92626, 92627, if performed on the same ear)
+92632	each additional 15 minutes (List separately in addition to code for primary procedure) (Use 92632 in conjunction with 92631)
92634	Hearing aid fitting services, unilateral or bilateral, including device analysis, programming, verification, counseling, orientation, and training, and, when performed, hearing assistive device, supplemental technology fitting services; first 60 minutes (Do not report 92634 in conjunction with 92636, 92637, 92642)
+92635	each additional 15 minutes (List separately in addition to code for primary procedure) (Use 92635 in conjunction with 92634)
92636	Hearing aid post-fitting follow-up services, unilateral or bilateral, including confirmation of physical fit, validation of patient benefit and performance, sound quality of device, adjustment(s) (eg, verification, programming adjustment[s], device connection[s], and device training), as indicated, and, when performed, hearing assistive device, supplemental technology fitting services; first 30 minutes (Do not report 92636 in conjunction with 92628, 92629, 92631, 92632, 92634, 92635, 92642)
+92637	each additional 15 minutes (List separately in addition to code for primary procedure) (Use 92637 in conjunction with 92636)
+92638	Behavioral verification of amplification including aided thresholds, functional gain, speech in noise, when performed (List separately in addition to code for primary procedure) (Use 92638 in conjunction with 93634, 92636) (Do not include the time for 92638 within the overall time used for reporting 92634, 92636)
+92639	Hearing-aid measurement, verification with probe-microphone (List separately in addition to code for primary procedure) (Use 92639 in conjunction with 92634, 92636) (Do not include the time for 92639 within the overall time used for reporting 92634, 92636)

	(For unilateral procedure, report 92639 with modifier 52)
92641	Hearing device verification, electroacoustic analysis (Do not include the time for 92641within the overall time used for reporting 92634, 92636) (For unilateral procedure, report 92641 with modifier 52)
92642	Hearing assistive device, supplemental technology fitting services (eg, personal frequency modulation [FM]/digital modulation [DM] system, remote microphone, alerting devices) (Do not report 92642 in conjunction with 92631, 92632, 92634, 92635, 92636, 92637, 92638, 92639)

Q: What was the process used to develop these new codes?

A: Member feedback regarding the lack of codes that accurately describe the professional services for evaluation, management, and treatment of hearing loss with air conduction hearing aids (and related hearing assistive technology) resulted in discussions by the relevant leadership at AAA and ASHA who assist with code development. Advocacy related to these services has been challenging as professional services are reflected in CPT codes, and not HCPCS II codes. With only a few CPT codes that do not adequately describe the professional services, it has been difficult to help payers understand and appreciate the value of the services being provided.

As with any new code development, an application is submitted to the AMA's Current Procedural Technology (CPT) Editorial Panel. The applicant, which in this case was AAA and ASHA, prepares an application that includes detailed vignettes for the typical patient, a detailed description of the procedure, and supporting evidence-based literature for each code. The proposed hearing device code set was developed by aligning existing clinical practices relating to hearing aids with past and current evidence-based published guidelines and practice standards.

The applicants attend the public CPT meeting to address any questions from the panel reviewers or that come from observers. Other interested parties, including any organization or individual, may address their concerns to the panel at the meeting. Once the CPT panel approves a new code, the applicant can decide whether to seek RUC valuation of the codes. The applicants opted not to seek valuation of these codes and instead chose to rely on carrier pricing. This decision was made as Medicare does not cover services related to hearing devices and the current CPT hearing aid codes were not RUC valued. In the development of the code structure, AAA and ASHA shared concepts and draft models for the codes with the Audiology Organizations group (a coalition of eight audiology organizations, including AAA and ASHA), and other interested parties, such as AAO-HNS, as required by the CPT Editorial panel. Feedback was sought, and many of those suggestions resulted in the final code set that was presented to the panel. Once a code is submitted, the CPT Editorial Panel and CPT Advisors can also make suggested changes to the application prior to the vote to approve or reject the code application.

Q: Why did I not hear anything about these new codes until now?

A: The AMA CPT process requires that applicants only share what is reported in CPT public documents. When an application is submitted, the applicant may not discuss it further with members or other interested parties. Once the CPT published the public summary of the February 2024 CPT meeting, the Academy and ASHA were able to share that 12 new hearing device services codes had been approved. The public release of the Medicare Physician Fee Schedule proposed rule for CY26 allowed AAA and ASHA to share additional information about the codes. After the

codes are assigned CPT numbers in the 2026 CPT manual, the Academy and ASHA will provide education to their members on their structure and use through a variety of media.

HCPCS Level II Codes (V-Codes)

Q: Are there changes to codes I use for hearing aid devices?

A: No. The new CPT codes pertain exclusively to **professional services** and do not affect the **HCPCS Level II "V-codes"** used to report hearing aid devices.

Q: Why were new CPT codes created rather than new HCPCS Level II V-codes for services?

A: While there are currently a few HCPCS Level II V-Codes that describe hearing aid related services, all new professional service codes must be developed through the CPT Editorial panel utilizing their processes.

Q: What happens if I currently use HCPCS codes (V-codes) to bill for hearing aid related services?

A: There is no recommendation to replace or modify the current legacy service-based V-codes. There are payer systems that will still need or will choose to use these codes instead for various reasons. The new CPT codes more accurately define the professional work, and as CPT codes, they also meet the high standards of clinical efficacy that payers require to add new procedures to their payment policies. Payer education is planned to assist them in their understanding of this modernized code set. Payers ultimately determine how they will utilize the new codes.

Q: My state Medicaid program currently requires unbundling hearing device services. Currently, we bill V5011 (fitting/orientation), V5090 or V5160 (dispensing fee monaural/binaural), V5020 (conformity evaluation) along with the appropriate code for the hearing aid(s). Will these new codes change how this billing is submitted?

A: No. There has been no change to the HCPCS Level II codes nor is there any plan to delete these codes. Payers will dictate which codes will be used for reimbursement of hearing device services.

Q: Can I still report V5014 for in-office repairs?

A: If insurance is involved, you will need to follow the payor's payment guidelines.

Hearing Aid Candidacy (CPT 92628 and 92629) Questions

Q: What if I am completing speech-in-noise testing outside of hearing aid candidacy – which code should I use?

A: There is currently not a separate code for speech-in-noise testing that can be reported with audiologic function tests.

Q: I work primarily with pediatric patients and speech-in-noise or suprathreshold testing are not appropriate for many of the patients. We complete pre-fitting questionnaires to supplement discussions with patients/family/caregivers regarding amplification options. Would this code be appropriate for these patients?

A: Yes. While some examples are provided in the descriptor for CPT 92628 (92629), appropriate pre-fitting questionnaires can be used as a part of the assessment of your patient's hearing needs.

Hearing Aid Selection (CPT 92631 and 92632) Questions

Q: Can I perform speech-in-noise testing during hearing aid selection?

A: Yes. Speech-in-noise testing can be performed if the information is needed to assist with the device selection. Speech-in-noise testing in this case will be considered part of the assessment and selection process and will not be separately reported and will be included in the overall time for the encounter.

Q: Is ordering the hearing aids included in the time of the hearing aid selection code?

A: No. The ordering of the hearing aids should be captured in overhead associated with dispensing durable medical equipment in your practice.

Q: For CPT code 92631, hearing aid selection services, if I do not include every element of the descriptor (e.g., assessment of visual and dexterity elements, etc.), am I required to utilize the -52 modifier, indicating a reduction in services?

A: No. The -52 modifier is not used with a time-based code. Based on the needs of the patient, the clinician determines which assessments need to be performed. For example, time may be needed to assess the dexterity of the patient to determine if they will be capable of manipulating the devices. In other cases, time may be needed to assess for and discuss the need for visual indicators when caregivers will need to monitor use of the devices. Because this is a time-based code, the provider has flexibility to choose which assessments are needed for the selection of a hearing device.

Hearing Aid Fitting Services (CPT 92634 and 92635) Questions

Q: When hearing aids arrive at the facility they are checked in, charged and may be preprogrammed, with the aid(s) being fit to the patient on a different date. Are any of these pre-fitting services captured in CPT 92634?

A: No, these pre-fitting services mentioned are not captured in 92634, as the code set is meant to capture the professional services provided during the patient encounter. The types of services mentioned should be captured in the overhead when dispensing durable medical equipment in your practice. If your practice performs electroacoustic analysis as a quality control measure, this service, CPT 92641 can be reported.

Hearing Aid Post-Fitting Follow-up Services (CPT 92636 and 92637)

Q: Can the post-fitting follow-up code be reported for new patients that need adjustments on their current hearing aids?

A: Yes, the post-fitting follow-up service codes can be reported when a face-to-face patient encounter relates to the care provided for existing hearing aids.

Verification Questions

Q: The behavioral verification code states it includes aided thresholds, functional gain and speech in noise. Must all components of the code be completed to report this code?

A: No. Aided threshold, functional gain and aided speech-in-noise tests are some of the options for completing objective behavioral verification. Your documentation should indicate the method(s)

chosen and results obtained to verify the function of the hearing aids for the patient. The reporting of CPT 92638 assumes verification has been completed in a sound treated booth with use of an audiometer or other equipment as indicated.

Q: Does the behavioral verification code include the administration of post-fitting questionnaires?

A: Post-fitting questionnaires are validation measures and are not included in the behavioral verification code. If appropriate, CPT 92636, the hearing aid post-fitting follow-up services code could be reported as this includes the validation of patient benefit and performance.

Q: What does "verification" mean as listed in CPT 92634 and 92636?

A: Verification, as listed in the descriptor of the code for hearing aid fitting and follow-up service codes, refers to simple verification methods such as loudness, speech understanding, or speech comfort measures performed without the use of special equipment. In addition, there are three objective verification measures that have their own code (CPT 92638, 92639, and 92641)) which can also be separately reported in conjunction with CPT 92634 and 93636. CPT 92638, 92639, and 92641 should not be included in the overall time used for reporting 92634 and 92636.

Q: Which code would be used if performing real ear measures or real-ear-to-coupler difference?

A: CPT 92639 (Hearing-aid measurement, verification with probe microphone) would be used for speech mapping, insertion gain or RECD measures. For unilateral procedure, report 92639 with modifier 52.

Q: Are there codes to report behavioral verification of the patient's hearing device(s)?

A: Yes, 92638 (Behavioral verification of amplification including aided thresholds, functional gain, aided speech in noise tests, when performed.) While the code descriptor provides examples of what may be performed, additional tests or other methods may be more appropriate for the patient. This code is intended to be used when verifying patient performance with a device(s) using an audiometer with the patient in the sound room.

Q: The legacy codes included codes to report electroacoustic analysis (92594, 92595). Is there a new code to report this service?

A: Yes. CPT 92641 (Hearing device verification, electroacoustic analysis) should be used to verify the function of the instrument and for quality control measurements. This code may separately be reported in conjunction with the hearing aid fitting and follow-up codes (92634 and 92636) or it may be reported when only this code is performed in isolation of other services. For unilateral procedure, report 92641 with modifier 52.

Q: Can CPT 92641 be used with devices other than air conduction hearing aids?

A: Yes. CPT 92641 can be used when electroacoustically evaluating an FM/DM device or when using a skull simulator to evaluate the function of the auditory osseointegrated devices.

Cochlear Implant and Auditory Osseointegrated Hearing Devices Questions

Q: Can I report 92634, 92635, 92636, 92637, 92638, and 92639 for fitting and follow-up services for cochlear implants and auditory osseointegrated hearing devices?

A: No. 92634, 92635, 92636, 92637, 92638, and 92639 are not intended for use with implantable or osseointegrated hearing devices. For cochlear implants, use 92601, 92902, 92603, 92604. For auditory osseointegrated devices, use 92622, 92623.

Q: What if my patient has a hearing aid on the other ear?

A: 92634, 92635, 92636, 92637, 92638, and 92639 services may be reported on the same date of service when providing air conduction hearing aid services on the contralateral ear.

Time-Based Versus Non-Timed Codes and Documentation Questions

Q: Is CPT code 92642 a time-based code?

A: No. CPT codes 92628, 92629, 92631, 92632, 92634, 92635, 92636, and 92637 are time-based. Please note the time in the code descriptor and/or refer to the table included in the "Documentation for Time-Based Codes" section of this document. Codes 92638, 92639, 92641, and 92642 are not time-based.

Q: How much total time must be used before I can report the time-based add on codes?

A: Please see the time-based minimum requirements table for information.

Q: Can the modifier -52, reduced services be used for the time codes if I don't meet the minimum time needed to report the code.

A: No, modifier -52 is not to be reported for time-based codes.

Q: What documentation is required for the time-based codes?

A: Providers must ensure that the activities of the encounter are clearly summarized in the medical record. This may include the non-timed coded that have their own procedure codes and that vague references to time are avoided. Documenting start and end time of an appointment doesn't capture the full scope of clinical work and would not be sufficient for the documentation. In addition, should accounting of actual time be required in your facility, it is recommended that a statement like the following be utilized: "***Total time spent caring for [patient] today was [x minutes]. This includes time spent before the visit reviewing the chart, time spent during the visit, and time spent after the visit on documentation…****"*

Additionally, if separately reporting procedures not included in the time, it is advised to add a note like the following to prevent confusion, "*Total time excludes the time for [(list separately reported code(s)].*"

Q: What documentation is required for the non-time-based objective verification codes (CPT 92638, 92639, 92641?)

A: The results, graphs, and/or curves should be included in the patient's medical record.

Q: CPT 92628 and 92631indicate in the descriptor "with report." Is the completion of the report included in the time requirement for the code?

A: Yes. "With report" indicates a summarization of the patient encounter and is included in the medical record.

Time-based minimum requirements table:

CPT Code	Service Descriptor	Time in Code (Minutes)	Minimum Time to Report (Minutes)
92628	Evaluation for hearing aid candidacy	30	16-37
+92629	Evaluation for hearing aid candidacy	15	Each additional 15 minutes starting at 38 minutes
92631	Hearing aid selection	30	16-37
+92632	Hearing aid selection	15	Each additional 15 minutes starting at 38 minutes
92634	Hearing aid fitting	60	31-67
+92635	Hearing aid fitting	15	Each additional 15 minutes starting at 68 minutes
92636	Hearing aid post-fitting follow-up services	30	16-37
+92637	Hearing aid post-fitting follow-up services	15	Each additional 15 minutes starting at 38 minutes
+92638	Behavioral verification	Not time-based	Not time-based
+92639	Probe-microphone verification	Not time-based	Not time-based
92641	Electroacoustic analysis verification	Not time-based	Not time-based
92642	Hearing assistive devices services	Not time-based	Not time-based

Valuation Questions

Q: Why don't I see any values for the codes in the CY26 MPFS proposed rule?

A: The RUC has recommended carrier pricing for the new codes which means that payment would be determined by the individual payors. Medicare does not cover these services because Federal statute specifically excludes from coverage "hearing aids or examinations for the purpose of prescribing, fitting, or changing hearing aids". CMS is proposing to assign non-payable status to each of the new 12 CPT codes.

Q: Were the legacy hearing aid codes (CPT 92590-92595) valued?

A: No. They had no work RVU and were carrier priced.

Q: My hospital uses RVU's for productivity. How can this be managed if there are no RVU's assigned?

A: Eight of the codes are time-based codes, so this may assist with determining productivity in your facility.

Payment for Services Questions

Q: Will commercial payers begin using these codes on January 1, 2026?

A: While the new CPT codes will be available for use on January 1, 2026, it often takes payers some time to adopt new CPT codes and activate them in their systems. Planned payer advocacy and education will help payers understand the new code structure.

Q: We unbundle hearing devices services in my practice. How will these new codes impact unbundled services?

A: While many practices have already been unbundling their professional hearing device services, the legacy CPT code set did not address many of the services that were being provided. Additionally, the HCPCS Level II V-codes have no descriptors, leaving interpretation of those services to individual payers. We believe the modernized code set better captures the professional work involved and will allow for greater consistency and transparency for patients and payers.

Q: Should I continue to report V5014 for minor repairs such as tubing and tone hook changes?

A: Yes, V5014 may continue to be reported for repairs subject to payer and practice policies.