

## Hearing Testing

### Coding Specifications

Codes required to document patient has otitis media with effusion (OME) and received tympanostomy tube insertion:

A line item ICD-9-CM diagnosis code for OME and a CPT procedure code for tympanostomy tube insertion are required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

#### OME line item ICD-9-CM diagnosis codes

- 381.10, 381.19 (chronic serous otitis media),
- 381.20, 381.29 (chronic mucoid otitis media),
- 381.3 (other and unspecified chronic nonsuppurative otitis media),
- 381.4 (nonsuppurative otitis media, not specified as acute or chronic)

AND

#### CPT procedure codes

- 69433, 69436 (tympanostomy)

Quality codes for this measure:

#### CPT II Code descriptors

(Data Collection sheet should be used to determine appropriate code.)

- **CPT II 3230F:** Documentation that hearing test was performed within 6 months prior to tympanostomy tube insertion
- **CPT II 3230F-1P:** Documentation of medical reason(s) for not performing hearing test within 6 months prior to tympanostomy tube insertion
- **CPT II 3230F-3P:** Documentation of system reason(s) for not performing hearing test within 6 months prior to tympanostomy tube insertion
- **CPT II 3230F-8P:** Hearing test not performed within 6 months prior to tympanostomy tube insertion, reason not otherwise specified

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