healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Brainstem Auditory Evoked Potentials and Responses (BAEPs/BAERs)		
Policy Number:	PO-RE-136v1		
Effective Date:	07/1/2025	**Last Approval Date:**	05/19/2025

I. Policy Description

This policy outlines the reimbursement guidelines for Brainstem Auditory Evoked Potentials (BAEPs) and Brainstem Auditory Evoked Responses (BAERs) testing, in accordance with Local Coverage Determination (LCD) L34975 and Local Coverage Article A56773, Jurisdiction H and L. BAEP/BAER testing is utilized to assess the auditory pathways in the brainstem and is essential for diagnosing various auditory and neurological conditions.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Medicare PPO
- Essential Plan (EP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)

Reimbursement Guide

1. Coverage Criteria:
   BAEP/BAER testing will be covered when performed for patients who meet the following criteria:
   - Age limits: >18 years.
   - The testing is deemed medically necessary based on the patient's clinical presentation.
   - The procedure is performed by qualified healthcare professionals in a suitable clinical setting.

2. Acceptable Diagnosis Codes:
   The following list of diagnosis codes are examples of acceptable diagnosis codes for Brainstem Auditory Evoked Potentials and Responses (BAEPs/BAERs):

   - Conductive and sensorineural hearing loss (H90.0-H90.8)
   - Malignant neoplasm of cerebellum (C71.6)
   - Multiple sclerosis (G35)

- Tinnitus (H93.1-H93.19)
- Vertigo of central origin (H81.4-H81.49)

3. Procedure Codes:
   The following CPT codes should be used when billing for BAEP/BAER testing:

   - 92651: Auditory evoked potentials; threshold evaluation and speech perception tests
   - 92652: Auditory evoked potentials; brainstem response, comprehensive
   - 92653: Auditory evoked potentials; brainstem response, limited

4. Documentation Requirements:
   Providers must maintain comprehensive documentation in the patient's medical record, including:

   - A detailed clinical history outlining the reason for the BAEP/BAER test.
   - Results of any prior evaluations or tests related to auditory function.
   - A clear interpretation of the test results by the provider.
   - Corresponding diagnosis codes that justify the medical necessity of the testing.

Adjudication and Appeal Process

1. Reimbursement for BAEP/BAER testing services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

II. Applicable Codes

Code	Description	Comment
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	

92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	

III. Definitions

Term	Meaning
BAEP	Brainstem Auditory Evoked Potentials
BAER	Brainstem Auditory Evoked Responses

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Article - Billing and Coding: Neurophysiology Evoked Potentials (NEPs) (A56773)
LCD - Neurophysiology Evoked Potentials (NEPs) (L34975)

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.