Internal Medicine Coding Alert

Payment for Cerumen Removal Depends on the Reason for a Visit

Many internists and their coders are confused about how to code for impacted cerumen removal, partly as a result of a 2000 Medicare policy bulletin that many misinterpreted to mean that Medicare would never pay for both an office visit and cerumen removal on the same day. Medicare will sometimes pay for both, but only when certain criteria are met.

The key to whether Medicare will pay for both codes can be found in the reason your patient came to the office: Did he of she come in for cerumen removal, or for a different health problem?

Medicare will pay for both an E/M visit and 69210 (Removal impacted cerumen [separate procedure], one or both ears) only when the patient has come to the office for a significant, separately identifiable service and during the course of the examination:

impacted cerumen is found

removal is deemed medically necessary

the cerumen is removed in a procedure performed or supervised by the physician or nonphysician practitioner

removal requires significant effort by the provider.

If the patient comes in specifically for impacted cerumen removal, a separate E/M service cannot be coded. The key to understanding this is "to remember that impacted cerumen removal is a surgical procedure with a zero-day global period," says **Kim Pollock, RN, MBA,** a consultant for Karen Zupko & Associates, a Chicago-based practice management firm. "We need to understand Medicare's theory behind the global concept for surgery."

During a zero-day global period for a surgical procedure, an E/M service that is related to the surgical procedure and is provided on the same day as the surgical procedure is included in payment for the procedure. Therefore, an office visit would not be coded along with 69210 when impacted cerumen is the reason for the visit.

Coding Both an E/M and a Cerumen Removal

"The best way to report both the cerumen removal and an E/M visit is to have a completely different diagnosis code for the E/M, then add modifier -25 [Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service] to the E/M code," says Pollock.

The following example of a situation where both codes could be used is from **Mary Falbo, MBA, CPC,** president of Millennium Healthcare Consulting Inc. in Lansdale, Pa., which provides coding, compliance, billing assessment and educational services to health systems and physicians' practices in the mid-Atlantic region.

A 68-year-old man comes in with symptoms of influenza and an upper respiratory infection, including nasal and ear congestion and a cough. During the course of the examination, the physician discovers impacted cerumen obstructing the view of the eardrum. The physician removes the impacted cerumen and also prescribes medications for the cough and congestion. For an established patient, assign the appropriate E/M code (99212-99215) with diagnosis codes 487.1 (Influenza with other respiratory manifestations) and 381.81 (Dysfunction of Eustachian tube) and append the -25 modifier to the E/M code. Also report 69210 with a diagnosis code of 380.4 (Impacted cerumen).

Falbo notes that removal of the cerumen must require "significant effort on the part of the physician, and that needs to

be documented in the patient's record."

Offices will have the greatest success in securing reimbursement for both an E/M and 69210 when the diagnosis for the E/M is clearly different from impacted cerumen, Pollock says. For example, if the diagnosis linked to the E/M code is pneumonia, you'll fare better than if the E/M diagnosis is 388.30 (Tinnitus, unspecified). If tinnitus is the diagnosis, it may seem reasonable to the payer to conclude that the two services are not "separate" and that the physician had to remove the cerumen simply to examine the ears to diagnose the problem.

"Anything in the 380 series of ICD-9 is going to be a problem," says Pollock. However, Pollock doesn't recommend against using a diagnosis code in the 380 series for an E/M visit along with cerumen removal if the office has strong documentation clearly showing the separate nature of the services. "Your claim may initially be denied in that case," she says, "but I'd appeal it."

Be Specific with Your Words

When both an E/M and 69210 are reported, the physician must provide clear documentation of the cerumen removal. After you record the history, exam and other elements of the E/M visit, skip a line and write the word "Procedure." Then provide a description. "'Cerumen removal' is not enough," Pollock says.

The note should include how the cerumen was removed, how difficult it was to remove, how the patient tolerated the procedure and a description of the qualities of the cerumen removed.

Reporting a Visit for Cerumen Removal Only

When a patient comes in specifically for impacted cerumen removal, offices should not attempt to secure reimbursement for both an E/M visit and the cerumen removal.

For example, an elderly woman who wears a hearing aid finds cerumen accumulating often and comes in every three months for removal. "If that is the sole reason for the visit, the only service I recommend reporting is cerumen removal no E/M code," Pollock says.

To secure reimbursement for 69210, the physician needs to document that the procedure was medically necessary, that he or she or a nonphysician practitioner performed or supervised the removal, and that a lot of effort was required to remove the cerumen, Falbo notes.

Code 69210 carries a reimbursement rate higher than some E/M codes. The reimbursement rate for 69210 is 1.24 relative value units (RVUs), for a (national, not adjusted for region) payment of about $44.89. Compared to the approximate payment for established E/M codes, that is more than 99212 ($36.20, at 1.0 RVUs) and slightly less than 99213 ($50.32, at 1.39 RVUs).

Avoid Five Common Mistakes

The following tips help you avoid denials for 69210:

1. Do not use 69210 for cerumen removal if the cerumen is easily removed or if office staff other than the physician or nonphysician practitioner perform or supervise the procedure. This is considered simple cerumen removal and should instead be included as part of an E/M.

2. Be sure to link 380.4 to 69210. One of the chief reasons for denial of cerumen removal claims is the coder's use of an incorrect diagnosis code, Falbo says. For example, offices may mistakenly link 389.9 (Unspecified hearing loss) or 381.81 to 69210. "That's not going to get the procedure paid," Falbo says. "The only diagnosis code that Medicare will accept for impacted cerumen removal is 380.4."

3. Check with your local Medicare carrier for restrictions. For example, Florida's First Coast Service Options Inc. will pay

for 69210 only if the cerumen removal is done via the manual disimpaction method, in which the physician uses forceps, suction or a right-angle hook to remove the cerumen under binocular magnification. It considers irrigation or chemical solvents to loosen the cerumen as part of the E/M service and says the procedure is not separately reimbursable with those methods.

4. Do not code 92504 (Binocular microscopy [separate diagnostic procedure]) with cerumen removal. This code is for binocular microscopy done as a separate procedure, not as part of a surgical procedure, Pollock notes. Payment for binocular microscopy is bundled into 69210.

5. List 69210 only once. The code description indicates removal from one or both ears.