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Internal Medicine Coding Alert

3 Tactics Meet Cerumen Removal Coding Head On

These tips tell you when to use (or not use) 69210.

To code or not to code? That is the question for many internists and their coders when it comes to the issue of removing impacted cerumen.

Here are three tips to help you determine when to use, or not use, 69210 (Removal impacted cerumen [separate procedure], one or both ears).

1. Check If Wax Is Impacted

The first thing that you need to do is to fully understand the definition of impacted cerumen (384.0). "Remember that 69210 is actually a surgical procedure," urges **Kris Cuddy, CPC, CIMC**, independent consultant in DeWitt, Minn.

The American Academy of Otolaryngology-Head and Neck Surgery (AAOHNS) reports that if any one or more of the following are present, cerumen is considered clinically "impacted":

• **Visual considerations**: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.

• **Qualitative considerations**: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.

• **Inflammatory considerations**: Associated with foul odor, infection, or dermatitis.

• **Quantitative considerations**: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.

2. Absent Instrumentation? Use E/M, Not 69210

"The ear lavage, which is sometimes confused with cerumen removal, is actually part of an E/M visit and able to be performed by a nurse," explains **Karen K. Byrne, RN, BS, CPC, CEMC,** coding analyst, Carolina Health Specialists, Myrtle Beach, S.C. "There is no specific code for lavage including water piks." Removing wax that is not impacted also does not justify 69210. This work is captured by an E/M code -- no matter how it is removed.

According to the AAOHNS, the following scenarios do not justify the use of 69210:

Patient scenario #1: The patient presents to the office for the removal of "ear wax" by the nurse via irrigation or lavage. This service is captured by the appropriate E/M code.

Patient scenario #2: The patient presents to the office for the removal of "ear wax" by the primary care physician via irrigation or lavage. This service is also captured with the appropriate E/M code.

"Ear irrigation or ear lavage without any separate provider use of instrumentation should be included in the E/M service selected for that day," confirms Cuddy. "The work performed should be appropriately documented -- no matter which staff member provided the service. Appropriate documentation will allow the provider to include the work in his/her E/M selection."

3. Use 69210 When Chart Contains 5 Points

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According to Medicare's Local Coverage Determination (L28170), payment is made for impacted cerumen removal requiring a physician's skill when personally performed by a physician.

If the wax is truly impacted (refer to the criteria above), then removal may be reported with 69210 if performed by a physician using, at minimum, an otoscope and instruments such as wax curettes or an operating microscope and suction, plus specific ear instruments (e.g., cup forceps and right angles). Accompanying documentation should report the time, effort, and equipment needed to perform the procedure.

Cuddy advises that "documentation must include the following:

• the fact that cerumen impaction was observed, along with the location(s);

• the instrumentation used (and any magnification);

• the removal procedure;

• the procedure outcome; and

• patient care instructions."

Here is an example of how documentation should be approached: "Patient presents to office with complaint of ear wax.

The provider documents the patient's impaction in exam describing the area(s) within the ear that the wax is covering. The provider documents the removal of the impaction, including, but not limited to, the use of magnification and instrumentation (such as forceps, suction, ear wax curettes, etc). The provider documents the outcome of the removal and gives patient care instructions. Typically, documentation of care instructions will also include how the patient should and should not clean his ears at home."

The following scenario would warrant the use of 69210: The patient presents to the office for "ear wax" removal as the presenting complaint. This is described as impacted cerumen because it completely covers the eardrum and the patient has hearing loss. The impacted cerumen is removed by the internist with magnification provided by an otoscope or operating microscope and instruments such as wax curettes, forceps, and suction.

Code 69210 may be used here because both criteria were met: the patient had cerumen impaction and the removal required physician work using at least an otoscope and instrumentation rather than simple lavage.

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