Internal Medicine Coding Alert

Cerumen Removal: Here's How to Report E/M and 69210

Follow these guidelines to ensure cerumen removal payment.

In a follow-up to last month's article on when to use, or not use, 69210 (Removal impacted cerumen [separate procedure], one or both ears), here we discuss when it's okay to code 69210 with an evaluation and management (E/M) service.

There are some cases when a separately reportable E/M service, in addition to the procedure, is needed. For example, Medicare will pay for both an E/M visit and 69210 only when the patient presents 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; and

• removal requires significant effort by the provider.

Go For It! Use 69210 and E/M Code

"To avoid denials the first time," says **Kris Cuddy, CPC, CIMC**, independent consultant in DeWitt, Minn.,"use modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the E/M line of service when an E/M service is supported and billed with 69210." **Karen K. Byrne, RN, BS, CPC, CEMC,** coding analyst, Carolina Health Specialists, Myrtle Beach, S.C., adds that 69210 has the specific diagnosis of impacted cerumen (380.4). Hearing loss or pain may be due to impacted cerumen, but without impacted cerumen, 69210 is not applicable. The appointment may be scheduled for loss of hearing or ear pain, or may just be picked up as part of the E/M exam.

"In these cases, the diagnosis for the visit is the chief complaint or the results of the exam, such as otalgia, otitis media, or diabetes. I would add modifier 25 as a separate distinct service," says Byrne.

Here is an example of an established patient who reports to the internist for a checkup of her type II diabetes mellitus (250.00). This scenario will allow you to report 69210 and an E/M:

During the evaluation, the patient complains of decreased hearing in her right ear. After providing a leveltwo E/M service for the patient's diabetes, the internist examines the patient's ears and finds impacted cerumen; he removes it using instrumentation.

Definition: According to article A44326, "Removal of impacted cerumen and evaluation and management services" from the Medicare Local Coverage Determination (LCD) for Alabama, Georgia, and Mississippi: "If a separate, identifiable evaluation and management service is provided during the same visit, then Medicare may cover an evaluation service if modifier 25 is added to the evaluation and management CPT code, indicating that the evaluation and management service was unrelated to the cerumen removal procedure."

So, on the claim for this example scenario, you would report the following:

• 69210 for cerumen removal

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- 380.4 (Impacted cerumen) linked to 69210

- 99212 (Office or other outpatient visit for the E/M of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making) for the E/M

- 250.00 (Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled) linked to 99212 to represent the reason for the E/M

- modifier 25 linked to 99212 to show that the E/M and cerumen removal were separate services for separate issues.

"Carriers' computer systems are sometimes set up not to pay on first submission, but if the documentation is clearly there as a distinct procedure, it usually wins on appeal. If a large carrier routinely denies the claim, create a form letter; it will save time on appeals," says Byrne.

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