Internal Medicine Coding Alert

Check Instrumentation for Clues to Accurate 69210 Coding

All cerumen removal services are not created equal

Failure to recognize impacted cerumen removal coding chances could hurt the practice's bottom line.

Check out this primer on identifying impacted cerumen claims.

Make Sure Cerumen Is Impacted

The key to proper code choice for cerumen removal lies with the diagnosis and the physician's actions. If the internist removes impacted cerumen with instrumentation, you can report 69210 (Removal of impacted cerumen [separate procedure], one or both ears) for the service, says **Kent Moore**, a healthcare finance manager in Leawood, Kan. If the internist (or a nonphysician practitioner, NPP) removes the cerumen with lavages or other solutions, you cannot use 69210.

"Impacted" definition: For coding purposes, "impacted" cerumen is "packed tightly in the outer ear, so much so that the external ear canal is blocked. The ear wax is hard and possibly crusted," says **Steve Verno, NREMTP, CMBSI,** director of reimbursement at EMS in Hollywood, Fla. Impacted cerumen may block the patient's tympanic membrane or cause hearing loss, Verno says.

Instrumentation Can Guide You to Proper Code

According to Moore, if your internist uses one of the following instruments to remove cerumen, the service likely qualifies for 69210:

• suction

• probes

• forceps

• right angle hooks

• wax curettes.

You should use these criteria as a base, but "different carriers may have different policies on cerumen removal," Verno says. The commonality is that the ear is impacted with cerumen and the physician performs the removal by means other than simple or lavage, and involves a significant process.

As an example, Verno notes the 69210 policy for Blue Cross-Blue Shield: "CPT code 69210 is eligible for reimbursement when the following criteria are met: The cerumen removal requires the skill of a physician, or the removal is directly supervised by a physician and the removal requires a significant amount of time and effort," states the policy.

Example: An established patient presents with several problems in his right ear. He says there's been constant ringing in the ear and severe itching in the canal for the last three days.

The internist checks the patient's left ear, which is clear. A right-ear check reveals extreme blockage of canal by crusty hard wax. Due to the obstruction, the internist cannot see the tympanic membrane. The internist removes a large piece of impacted cerumen using an earwax curette, suction and otoscope with a large speculum. On the claim, you should

report 69210. Also, attach ICD-9 code 380.4 (Impacted cerumen) to 69210 to prove medical necessity for the visit.

For some carriers, 380.4 is the only acceptable ICD-9 code for 69210. According to Riverbend GBA's local coverage determination (LCD) 1597, for example, the only diagnosis that supports medical necessity is 380.4.

However, there are other carriers that are more lenient on 69210 diagnosis coding.

Kansas Medicare LCD L9422 has 100 different diagnoses that support medical necessity for 69210, Verno says. If you have any doubt about a payer's cerumen removal policy, check your individual contract for specific info on proving medical necessity for 69210.

Opt for E/M on Non-Impacted Cerumen

When the physician removes cerumen without instrumentation, or when an NPP removes the cerumen, you will probably have to consider the removal a part of the overall E/M service and code accordingly, Verno says.

These cerumen removal encounters will likely result in a level-one or -two E/M, depending on the encounter specifics. Suppose the internist evaluates an established patient's ear and removes a small amount of wax with lavage and cotton swabs.

The internist diagnoses the patient with otitis media and places her on antibiotics for the middle ear infection. Notes indicate a level-two E/M.

On the claim, report 99212 for the service (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making).

Remember to link the otitis media diagnosis, such as 382.9 (Unspecified otitis media), to 99212 to represent the patient's ear infection.