Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: Do Not Bill 92504 With 69210

Question: The physician cleared cerumen impaction from the patient's left ear and purulent drainage from the right. He used the operating microscope to clear with suction bilaterally. We're thinking our best coding strategy might be 69210-LT with 92504-59-RT. What's your recommendation?

Illinois Subscriber

Answer: The claim should contain only one procedure code either the impacted cerumen removal (69210, Removal impacted cerumen [separate procedure], 1 or both ears) or the microscopy (92504, Binocular microscopy [separate diagnostic procedure]).

Reasoning: These codes are listed as "separate procedures" in the CPT® book. According to the CPT® separate procedure notes, procedures with descriptors containing this term "are commonly carried out as an integral component of a total service or procedure." These codes "should not be reported in addition to the code for the total procedure or service of which it is considered an integral component," according to surgery guidelines.

Result: When a physician performs a separate procedure and another procedure in the same area, CPT® includes the separate procedure in the other procedure. So, if the physician does anything in the ear with microscopy, CPT® includes 92504 in the other ear procedure, and the microscopy is not billable. Similarly, if the physician performs any ear procedure and also removes impacted cerumen, 69210 is included in the other ear procedure and is not billable.

CCI notes: Current CCI (Correct Coding Initiative) edits list 92504 as a column 2 code for 69210 with a "0" in the modifier column, which means you cannot bill the codes together in any circumstances. Code 92504 is bundled into code 69210 when provided to the same patient on the same date of service.

Bottom line: Bill only 69210 for the encounter. No modifiers are necessary.

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