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Internal Medicine Coding Alert

Want to Keep Your Cerumen Removal Coding Out of Trouble?

How your practice can make $48 a pop on 69210

Don't let confusion over coding guidelines wreck your next cerumen removal claim. The keys to assigning **69210** are knowing whether the earwax was impacted, how to report incident-to removal, and when you can separately submit codes for the procedure and office visit.

To get what you deserve for cerumen removal, our experts say you should implement these three tips:

1. Choose 69210 Based on the Physician's Method

When the internist removes a patient's cerumen, you should choose the appropriate code depending on the earwax's level of impaction and your carrier's coding guidelines.

If you report 69210 (Removal impacted cerumen [separate procedure], one or both ears), remember that the physician must have removed "impacted" cerumen, as specified in the code's descriptor. For simple cerumen, which the physician can easily remove without suction or forceps, use the appropriate E/M code (**99201-99205, 99211-99215**).

Tip: Let the physician's method for taking out the cerumen lead you to the right code. Although your carrier may not require the physician to use a specific instrument, the physician's work must be greater than if he had performed a simple earwax removal.

"If the physician used a syringe or water pick, that's when we report 69210," says Betty Mehlenbeck, CCS-P, an internal medicine coding and compliance auditor at HealthCare Network Associates in Springfield, Ill.

But if the internist uses a simple instrument, such as a curette, and the cerumen "comes right out," you should include the work in the E/M level, Mehlenbeck says. That's because payers will consider this service a simple cerumen removal, which doesn't warrant a separate code.

"We've had no problems with private payers or Medicare when billing this way," Mehlenbeck adds.

Warning: Your Medicare or private carrier may have different guidelines for reporting impacted cerumen removal. For instance, First Coast Service Options, Florida's Medicare carrier, will accept 69210 only when the physician uses manual disimpaction under binocular magnification to remove the earwax.

On the other hand, HGSAdministrators, Pennsylvania's Medicare provider, defines impacted cerumen removal as "the extraction of hardened or accumulated cerumen from the external auditory canal by mechanical means, such as irrigation or debridement."

But for nearly all insurers, you should link 380.4 (Impacted cerumen) to 69210 to support medical necessity.

Payment: Medicare pays $48 for 69210, according to national averages. Your reimbursement may be more or less, depending on your locality and payer.

2. Understand Incident-To Requirements

You may report 69210 when a nonphysician practitioner (for example, a nurse practitioner or physician assistant) removes impacted earwax as long as your Medicare or private carrier allows incident-to billing.

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For instance, Noridian Administrative Services, Washington state's Medicare carrier, pays for 69210 only if the physician or nonphysician practitioner performs the work, says Monie Sagoo, CPC, a quality care coordinator for internists and family physicians in Spokane. This means a registered nurse or medical assistant can't bill for the procedure.

First Coast Service Options, however, pays only for a physician's cerumen-removal services. When a nonphysician practitioner, nurse or medical assistant performs the work, the carrier considers the removal a part of the E/M service.

The bottom line: If your Medicare or private payer allows incident-to billing for impacted cerumen removal, remember these two tips:

1. **Your internist must directly supervise the procedure.** "Usually we have a doctor in the suite" who supervises a nonphysician practitioner taking out the cerumen, Sagoo says. **Example:** A patient presents with hearing loss (**389.x**), and following the examination, the physician schedules the patient to return in a few days for cerumen removal. When the patient returns, the physician assistant performs the procedure, while the physician remains in the office suite and supervises.
2. **The physician must initiate treatment.** Medicare requires that a physician write the initial order and follow up with the patient at regular intervals, says Marie Felger, CPC, a coding consultant with Joy Newby & Associates LLC in Indianapolis.

3. Bill Separate Visits With Modifier -25

If a patient comes to the office with vertigo (**780.4,** Dizziness and giddiness), and the internist decides to perform cerumen removal (69210), can you report both 69210 and an E/M code?

Yes, as long as the documentation shows that the E/M service was separate and identifiable, internal medicine coding experts say. The physician should document that he originally saw the patient for a reason other than cerumen removal.

Coding solutions: To report this scenario, attach 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 appropriate E/M code (for example, **99212**, Office or other outpatient visit ... established patient ...).

You should also link 780.4 to the E/M. You could assign 69210 for the removal, using ICD-9 code 380.4. Linking separate ICD-9 codes supports your claim that the physician provided separate, identifiable services.

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