Codify
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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 3 Expert Tips Help You Code Ear Diagnoses With Ease

From otitis media to cerumen removal, we've got all the answers to your ear coding questions

It's that time of year again -- when patients' head colds are leading to a variety of ear conditions. Look to our expert advice to ensure you're coding correctly for all of the ear-associated diagnoses.

1. Verify Documentation for E/M With 69210

Cerumen removal can present several coding challenges for your practice, particularly if the physician performs the service as a gateway to visualize the ear. Knowing when you can report 69210 (Removal impacted cerumen [separate procedure], 1 or both ears) is key to collecting for this service.

Example: Suppose a patient presents with ear pain, but the physician has to remove impacted cerumen before he can visualize the tympanic membrane. He subsequently diagnoses an ear infection. Your practice wants to bill an office visit and modifier along with 69210 -- is that acceptable?

Key: "Whether to report 69210 is always a value judgment because if you just flick a little wax aside to visualize the eardrum, you shouldn't bill for cerumen removal," says **Charles Scott, MD, FAAP,** with Advocare Medford Pediatric and Adolescent Medicine in New Jersey. "Typically, I'll use that code if I have to use a special device that allows me to curette the ear before I can visualize the tympanic membrane," he advises.

The July 2005 CPT Assistant states that cerumen is considered "impacted" in several circumstances, one of which is, "cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition." Therefore, if the cerumen is blocking the physician's view and he has to use special instrumentation to remove it above and beyond irrigation, most payers allow you to report 69210.

You should ensure that you have separate documentation of the E/M service and procedure to support reporting both codes. Some practices overuse 69210, which means many insurers don't recognize or compensate for it.

Modifier advice: When reporting 69210 with an E/M service, you should report the appropriate E/M from 99201- 99215 (Office or other outpatient visit for the evaluation and management of an established patient ...) with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) appended, along with 69210. Include diagnosis 380.4 (Impacted cerumen) on the 69210 claim, and an ear-related diagnosis (such as 382.00) on the E/M line item. Make sure your physician documents a separate procedure note for the cerumen removal --\" don't bury the procedure in the E/M note.

2. Don't Consider Cerumen Removal Code When it 'Falls Out'

Before you report 69210, you must ensure that you've documented a separately identifiable procedure.

Example: The physician extracts the end of a cotton swab that broke off inside a patient's ear and removes cerumen with the cotton swab. The documentation reads, "The cotton swab and attached stem of cardboard appears embedded in the ear canal, adjacent to the eardrum posteriorly. This was carefully removed using alligator forceps, and cerumen was withdrawn from the ear with the cotton swab." Can you report the cerumen removal in this instance?

Solution: This documentation would not support a claim for removing impacted cerumen, since it appears that the ear wax simply came out along with the cotton swab. In this case, you should report the foreign body removal only (69200,

Removal foreign body from external auditory canal; without general anesthesia).

3. When Treating Ear Pain, Match Coding to Final Diagnosis

Sometimes coders can get tripped up when they read a presenting diagnosis on a chart -- they'll submit that ICD-9 code as the final diagnosis, even if the physician finds a more definitive diagnosis during the visit. Ideally, the physician should be providing the definitive diagnosis, averting this problem.

Example: A patient presents to your office because of ear pain and the physician diagnoses earache with acute otitis media. The earache is considered inherent to the primary diagnosis, says **Susan Vogelberger, CPC, CPCH, CPC-I, CMBS, CCPP**, CEO of Healthcare Consulting & Coding Education LLC. Therefore, you should report only 382.00 (Acute suppurative otitis media without spontaneous rupture of ear drum).

"For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses," states the ICD-9-CM Official Guidelines for Coding and Reporting.

If, however, the physician does not find any other condition besides ear pain, he should code the ear pain diagnosis code instead (such as 388.70, Otalgia).