Coding for Removal of Impacted Cerumen (69210)

DAVID STERN, MD, CPC

Q. What is the correct use of CPT code 69210 (removal impacted cerumen [separate procedure], one or both ears)?

- Question submitted by Kathy Partenheimer, Medical of Dubois

A. In the July 2005 issue of *CPT Assistant*, the AMA clearly indicates that you should report 69210 only when the following two criteria are both met:

- "the patient had cerumen impaction"
- "the removal required physician work using at least an otoscope and instrumentation *rather than simple lavage*" [emphasis added].

Q. How does one determine that the cerumen is actually impacted so that code 69210 may be used for removal of the cerumen?

A. For the purpose of accurate coding, the AMA defines "impacted cerumen" in the July 2005 *CPT Assistant* as follows:

- "If any one or more of the following are present, cerumen should be considered 'impacted' clinically:
  - ***Visual considerations:*** *Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.*
  - ***Qualitative considerations:*** *Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.*
  - ***Inflammatory considerations:*** *Associated with foul odor, infection, or dermatitis.*
  - ***Quantitative considerations:*** *Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills."*

Q. If the physician removes cerumen as part of the exam but the cerumen is *not* impacted, what code would be appropriate?

A. A simplistic answer is that removing the wax is simply included in the emergency and management (E/M) code. The actual situation, however, is not quite so straightforward.

Since real-life medical coding is governed by multiple entities—including the AMA, CMS, and multiple private-sector payors—there are many areas of coding where conflicting interpretations exist. Such ambiguity exists in the application of the code 69210.

In this example, coders may make at least two interpretations:

- If you ask the physician if the wax was "impacted," he or she may indicate that, because the cerumen was not stuck tightly and filling the entire ear canal, the wax was not "clinically impacted."

  But be careful; you may be asking the wrong question. Before you give up too easily, ask the physician this question: "Why did you decide to remove the wax?"

  Chances are that the physician will tell you that the wax was getting in the way of performing an adequate otoscopic exam of the ear. If so, then the wax actually *does* meet the strict AMA coding definition (listed above) for impacted cerumen.

  Since the removal of this "required physician work using at least an otoscope and instrumentation," the procedure could be billable with code 69210.
- In some situations, however, using this code according to the strict AMA definition may still not be appropriate. As CMS cautioned in the *Federal Register* of June 29, 2006 (page 37233), "It is our understanding that CPT code 69210 is to be used when there is a substantial amount

David Stern is a partner in Physicians Immediate Care, with nine urgent care centers in Illinois and Oklahoma, and chief executive officer of Practice Velocity (www.practicevelocity.com), a provider of charting, coding and billing software for urgent care. He may be contacted at *dstern@practicevelocity.com*.

"It [is] not appropriate to use code 69210 unless the procedure required physician work."

of cerumen in the external ear canal that is very difficult to remove and that impairs the patient's auditory function. We will continue to monitor the use of this code for the appropriate circumstances."

To stay within the spirit of this definition, it seems best to avoid using this code for situations that only take a minute of the physician's time to scoop out the wax. Rather, most coders would recommend that code 69210 be reserved for use in situations where the cerumen removal takes significant effort by the physician.

This is a situation where many individual payors have set different policies for application of this code, so it is best to check with individual payors for their policy.

Q. As an urgent care center, can we also bill an office visit with a 25 modifier and a 69210 on the same day of service, especially if the doc examines the patient first and then determines that he needs an ear wash?

- Question submitted by Kathy Partenheimer, Medical of Dubois

A. An E/M code may be eligible for reimbursement in addition to code 69210 if *all* of the following criteria are met:

1. The patient's condition required a significantly, separately identifiable E/M service above and beyond the usual pre-service and post-service care associated with the removal of the impacted wax
2. The documentation requirements for use of that E/M code have been met
3. Modifier -25 is attached to the E/M code

When you are using 69210 for ear wax impaction, it is appropriate to use an E/M code (with modifier -25) if the patient received a true evaluation and management for a separate problem (such as bronchitis or pharyngitis) or for complicating problems (such as dizziness or otitis media). It is generally a good idea to include patient records with billings (or at least with appeals) to substantiate the medical necessity for a separate E/M.

On the other hand, if the patient comes in with a complaint of a "stuffy ear" and the physician determines that the patient has a cerumen impaction, removes the wax and there is no medical necessity for a separate evaluation and management, then one would code only the 69210.

A few payors require the coder to attach modifier -59 (distinct procedural service) to the procedure code (69210) and will not reimburse for the E/M when combined with modifier -25. Although this idiosyncratic coding requirement is truly frustrating, it may be the only way to get paid.

As always, check with your payor.

Q. At times, the nurses do an ear wash, and the physician does not perform any portion of the work involved in the cerumen removal. Is it appropriate to bill the 99211 with the 69210?

- Question submitted by Kathy Partenheimer, Medical of Dubois

A. Since no physician work was required, you should not use code 69210. Instead, you would only bill 99211. Because of the liability inherent in an ear wax removal (especially in the urgent care setting where the patient is not well known to the physician), I would personally advise against performing this procedure without a physician evaluating and documenting the condition of the ear(s) both before and after the ear lavage.

In this case, the correct E/M code would be a 99212 (or higher if indicated by medical necessity and documented appropriately), but it would not be appropriate to use code 69210 unless the procedure required physician work.

Q. If the patient requires removal of impacted cerumen from both ears, is it appropriate to add modifier -50 to the code 69210 to indicate that a bilateral procedure was performed?

A. No. Code 69210 is defined as "removal impacted cerumen (separate procedure), one or both ears." Use this same code only once to indicate that the procedure was performed, whether it involved removal of impacted cerumen from one or both ears.

Q. What are the appropriate ICD-9 diagnosis codes to justify billing for 69210?

A. Medicare accepts many different ICD-9 codes as "supporting medical necessity." By definition, however, 69210 always involves the diagnosis of impacted cerumen, so it seems reasonable to always attach the code for *impacted cerumen* (380.4) to the code 69210.

Of course, the physician documentation should clearly demonstrate the presence of impacted cerumen, as defined above. If you are attempting to code an E/M code in addition to code 69210, appropriate coding of an additional diagnosis is often helpful to reduce denials. ■