CODING Q&A

2014 CPT Changes, Suture Removal, Place of Service Code

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Q. I understand that we will be able to bill for cerumen removal for both ears in 2014. Is that true?

A. Yes. In 2014, you will be able to bill CPT code 69210, "Removal impacted cerumen requiring instrumentation, unilateral" with modifier -50, "Bilateral procedure." Keep in mind, Medicare will typically not cover simple, non-impacted earwax removal. CMS requires that physicians meet the following criteria for reimbursement of the removal of impacted cerumen:

- The procedure is the sole reason for the patient encounter;
- A physician or non-physician (nurse practitioner, physician assistant, or clinical nurse specialist) carries out the treatment;
- The patient in question is symptomatic; and
- The supporting documentation shows significant time and effort spent performing the service. ■

Q. Are there any changes to 2014 CPT codes?

A. A few changes to CPT codes in 2014 that are pertinent to urgent care include:

- The deletion of 13150, "Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less." You are now directed to simple or intermediate repair codes.
- 72040, "Radiologic examination, spine, cervical; 2 or 3 views." The phrase "or less" was removed from the description of number of views. Thus, for a one-view x-ray of the cervical spine, you will code 72040 with modifier -52 (reduced services.) Make sure that you bill your normal fee for the code because the payor will make payment reductions, generally as a percentage of what you bill or the payor fee schedule for the code, whichever is lower.

"Medicare will typically not cover simple, non-impacted earwax removal."

There are also some vaccine codes that were recently approved by the FDA and released for use in 2013 but not included in the CPT manual until 2014:

- 90673, "Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutnin (HA) protein only, preservative and antibiotic free, for intramuscular use."
- 90685, "Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use."
- 90686, "Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use."
- 90688, "Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use."

Still awaiting FDA approval, but added to the 2014 CPT manual is 90687, "Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use." You can find all 2014 changes in Appendix B of the 2014 CPT manual. ■

Q. If a patient comes into our urgent care center for removal of sutures that were placed by another facility, would we bill an E/M code and append modifier -55?

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"You can find all 2014 changes in Appendix B of the 2014 CPT manual."

A. It is compliant in some circumstances to bill suture removals, using the wound repair code with modifier -55 (*post-operative care only*).

There are a few issues with this:

- Simple wound repairs (vast majority of suture removal visits that you will see) have a zero-day global period, so modifier -55 would not apply to the visit for suture removal. You would just use an E/M code to code for the suture removal visit, whether the wound repair was initially done in your clinic or in another facility.
- You may not be aware of whether the initial provider coded the initial visit as a simple vs. intermediate/complex wound repair, so you will often not know whether the modifier -55 would even apply.
- For any patients who are still in a global period for their wound repair (intermediate and complex wound repairs), you could code with modifier -55. Getting payment on these will generally take more than 6 months, a substantial number of phone calls, and substantial stress:
  - You will usually get an initial denial because the initial provider did not append modifier -54 (*surgical care services only*) to the procedure. Thus, the initial provider will have been paid the global fee.
  - You will need to get the initial provider to refile the claim (after you get a denial) with modifier -54. That provider will generally be unhappy, very slow, or refuse to do this.
  - If the initial provider agrees to refile the claim, and after you confirm that the initial provider has refiled the claim, you can rebill the claim and get it to process.

Thus, unless you have coordinated this billing process in advance with the other provider, the use of modifiers -54 and -55 is very hard to coordinate and execute efficiently. ■

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