CODING Q&A

Workers' Compensation Visits, Cerumen Removal

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Q. I have a question on coding Workers' Compensation claims. I work in a hospital system and hospital coders oversee our charts. I feel they under code for the work we do. They are afraid of audits and refusal to pay. Typically, they will return the chart so that I can document my time and then they will charge for the time spent instead of the documentation.

I'm told there are no "bullet points" or increase in medical decision-making for discussing over-the-counter (OTC) medication instead of prescribing NSAIDs or narcotics, reviewing mechanism of injury or ergonomics of their job, handouts on exercises or review of stretching/exercises, discussing/making restrictions at the work site, or filling out forms for return to work/restrictions. I believe there are more layers of decision-making throughout the whole Workers' Compensation visit.

A. Although it requires more work to see a Workers' Compensation patient (for the same injury as a non-Workers' Compensation patient), more and more Workers' Compensation payors are insisting on less reimbursement for this work. In addition, the coding rules that we have from CMS do not give us extra credit for the extra work we do on these cases.

Time is unlikely to be very helpful as a coding guide because the E/M guidelines specifically preclude use of time for coding the E/M unless over half of the face-to-face time of the visit is composed of counseling or coordination of care, which is rare in urgent care. Thus time is mostly irrelevant for E/M coding in your setting.

Some modifications to the complexity of medical decision-making have been proposed to allow for coding credit for the additional work required to see a Workers' Compensation patient. Although these modifications are in use by some occupational health providers, CMS is not likely to ever formalize these modifications as coding for Workers' Compensation has always been ignored by CMS. This is not surprising as Medicare and Medicaid do not cover Workers' Compensation injuries.

You are correct that the work involved in discussing medications, exercise handouts, and work restrictions; reviewing mechanism of injury; and filling out work forms does not increase the medical decision-making factor for the E/M level. However, CPT codes for filling out forms are listed on the Workers' Compensation fee schedule for some states. Some states will accept CPT 99080, "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form" and others may have their own codes. For example, California has created its own set of 5-digit codes that begin with the letters "WC." ■

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Q. Our claims for ear irrigation are being denied. We usually bill 69210- RT-59 and 69210-LT-59. What are we doing wrong?

A. Irrigation alone is considered part of the E/M code and is not separately payable. For 2014, CPT did change its description of code 69210, "Removal impacted cerumen requiring instrumentation, unilateral." This change clarified that the code is unilateral and that physicians must use some type of instrumentation to remove impacted cerumen.

CPT defines cerumen as impacted if any one or more of the following conditions are present:

- Cerumen impairs the examination of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition; (Note: This is almost always the case when cerumen removal is performed.)
- Extremely hard, dry, irritative cerumen causes symptoms such as pain, itching, hearing loss, etc.;

CODING Q&A

- Cerumen is associated with foul odor, infection, or dermatitis; or
- Obstructive, copious cerumen cannot be removed without magnification and multiple instrumentations requiring physician skills.

Instrumentation is defined as the use of an otoscope and other instrumentation such as wax curettes, wire loops, or suction plus specific ear instruments such as cup forceps or right angle hook.

Some payors will require an RT and/or LT modifier while some will require modifier -50 appended to code 69210. Others may require you to list 69210 twice and append modifier -50 to the second line. Check with individual payors for preference. If the procedure is performed alone, just bill the code and appropriate modifier. If performed with other procedures, bill the code with the appropriate RT/LT/50 modifier(s) and also append modifier -59.

Unfortunately, the Centers for Medicare and Medicaid Services (CMS) have elected to ignore the change and pay the same for cerumen removal whether you do one ear or both. CMS stated its opinion that the procedure will typically be done on both ears at the same encounter because "the processes that create cerumen impaction likely would affect both ears." Per CMS instruction, this reimbursement policy will remain in place through 2014. Due to this decision, you will likely receive a denial if you try to bill Medicare for more than one unit for code 69210 since most Medicare Administrative Contractors (MACs) are denying these claims entirely and not even paying for one unit.

In order to bill an E/M visit and cerumen removal on the same date of service, the following criteria must be met:

- The initial reason for the visit was separate from the cerumen removal.
- Otoscopic examination of the tympanic membrane is not possible due to the impaction.
- Removal of the impacted cerumen requires the expertise of the physician or non-physician practitioner and is personally performed by him or her.
- The procedure requires a significant amount of time and effort.

All of the above criteria must be clearly documented in the medical record. Modifier -25, "significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service" should be appended to the E/M visit code, if applicable. Clinical notes must clearly indicate that the E/M and cerumen removal are separate and medically necessary services. ■

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