Evaluating the visit as the patient

Recently, we had an auditing tip on cerumen removal services (69210). This week, the tip is more of a commentary, and I hope it pushes all of us to give more thought to the office visit process. We often look at healthcare as a global topic, but when we look at it from the perspective of our own child being treated, it takes a different shape.

I took my daughter to the doctor last week with complaints of ongoing ear pain and difficulty hearing. Acting as Dr. Mom, I had performed multiple ear lavage sessions over the course of about a month with no relief or improvement in my daughter's discomfort, hearing loss, or all-round misery in her ears. Our provider, Dr. Snyder, treated my 16-year-old and told me that her ears are 100% blocked. She used a curette to remove the wax buildup and spent about 5-10 minutes in the room with us. Then a nurse came in and lavaged my daughter's ears for about 20 minutes (they were that bad). Dr. Snyder returned for another look and used forceps to remove additional debris, taking another 5-10 minutes to wrap up the encounter.

The auditor in me knows that 69210 can only be reported with the E/M code if modifier 25 is appended (and supported). Based on the limitations the NCCI edits place on modifier 25, it would not be supported in this instance, and thus even with the great job Dr. Snyder did with my daughter, the 69210 wouldn't be reportable with the E/M. Then I considered the E/M code and its proper level. The total encounter time was 30 minutes, but 20 minutes of that time was spent by the nurse, and although she also did a great job with my daughter, her time could not be counted. Not to mention that this visit couldn't be billed based on time to begin with, because counseling and coordination of care did NOT dominate the encounter.

Technically, the office visit should be dropped in this scenario and only the 69210 should be billed. Even though there was an evaluation, exam, and creation of a plan of care (not just RTC), the rules say that this 30-minute patient interaction would only get a $45 reimbursement. Quite honestly, it's embarrassing to know how little Dr. Snyder will be paid, sort of like going to tip someone and forgetting cash, so all you have is pocket change. Most patients don't understand this because they aren't auditors and don't know the complexities involved or the ambiguous guidelines we must work with. They don't realize that based on the effort Dr. Snyder put in, she should have been paid approximately $120 (E/M visit and 69210), but the rules left her with $45 instead. Will we soon reach a point in when providers no longer bother performing such minor procedures?
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It has been predicted that in the next year or so that modifier 25 may become extinct, and we already see some of the commercial payers moving in this direction. How will this affect such encounters? Will Dr. Snyder and others like her be forced to send these patients straight to ENTs instead of performing these procedures, just because of low reimbursement?

Our society wrestles constantly with health issues, including obesity, cancer, and mental health, but we have a healthcare system that makes it harder to get the care we need. What can we do? We can't file claims which violate the rules because we feel we "deserve" higher reimbursement, because this could rightly be construed as fraud, but we can begin to build awareness by sending written appeals to MACs, and commercial payers, and ask others in the industry to support our cause.

Our NAMAS Membership includes auditors who work on the physician side of healthcare as well as those who work with payers. Quite honestly, we are all working toward the same goal of compliance. We are all fraud investigators committed to the integrity of the rules we are given to follow, but it doesn't mean we have to agree with all of them in all situations.

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