REMOVAL OF IMPACTED CERUMEN

File Name: removal_of_impacted_cerumen
Origination: 4/2010
Last Review: 12/2022
Next Review: 12/2023

Description

Impacted cerumen removal is the extraction of hardened or accumulated cerumen (ear wax) from the external auditory canal by mechanical means, such as irrigation or debridement.

Generally, the simple/routine removal of cerumen (e.g., softening drops, use of cotton swabs and/ or cerumen spoons) is considered a part of the office visit and therefore cannot be separately reimbursed on the same day as an Evaluation and Management (E&M) service.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will provide coverage for the removal of impacted cerumen when the medical criteria and guidelines outlined in this policy have been met.

Reimbursement Guidelines

Payment may be made for the removal of impacted cerumen when the service is the sole reason for the patient encounter, and ***when the definition of impacted cerumen is met*****.** To be considered clinically impacted cerumen, the physical findings must be consistent with one or more of the following:

1. Visual considerations. Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
2. Qualitative considerations. Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.
3. Inflammatory considerations. Associated with foul odor, infection, or dermatitis.
4. Quantitative considerations. Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentation requiring advanced practitioner skills. (physician or non physician practitioner, such as nurse practitioner, physician assistant, clinical nurse specialist).

When cerumen removal is the sole reason for the encounter, the E/M service is included in the fee for the removal of impacted cerumen. Therefore, an E/M is not separately payable.

II. Payment consideration may be made for both the procedure ***and*** the E/M service if all of the following conditions are met:

1. The diagnosis of the E&M visit is other than the removal of impacted cerumen.

2. During an unrelated patient encounter (visit), a specific complaint or condition related to the ear (s) is either discovered by the physician or brought to the attention of the physician/non-physician practitioner by the patient.
3. The definition of impacted cerumen is met according to Section I of this policy.
4. Documentation is present in the patient record to identify the above criteria (II.1-3) have been met.
5. Modifier 25 must be submitted with the E&M code for proper adjudication to indicate a significant, separately identifiable evaluation and management service was performed.

Simple cerumen removal when performed by the physician or office personnel (e.g., nurses, office technicians) should not be separately reported and is not separately payable when the definition of impacted cerumen is not met.

An E&M service and the removal of impacted cerumen are not separately payable when the sole reason for the patient encounter is for the removal of impacted cerumen.

Cerumen removal is not covered when the patient is asymptomatic (e.g., denies pain, hearing loss, vertigo, etc.).

Visualization aids, such as, but not necessarily limited to, binocular microscopy, are considered to be included in the reimbursement for 69210 and G0268 and should not be billed separately.

Cerumen removal is not covered when billed with audiologic function tests.

Rationale

Documentation Requirements:

When this service is reported in addition to an E/M service, the medical record must clearly reflect the procedure was separate from the reason for the E/M encounter.

The documentation in the medical record must clearly reflect that the service required significant effort and time of the physician or non physician practitioner.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com .

Note: effective 1/1/2014 CPT 69210 describes a unilateral procedure. To report a bilateral procedure, append Modifier 50 with "2" in the units field.

Cerumen removal is considered incidental to audiologic function tests.

CPT® / HCPCS Code / Modifier	Description

69209	Removal impacted cerumen using irrigation/lavage, unilateral
69210	Removal impacted cerumen requiring instrumentation, unilateral
G0268	Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
Modifier 50	Bilateral Procedure

Related policy

Bundling Guidelines

References

Senior Medical Director review April 2010

American Medical Association. CPT Assistant. July 2005. Volume 15, Issue 7.

Medical Director – 5/2012

Medical Director review – 11/2013

History

7/1/10	Implementation of new policy. BCBCNC will provide coverage for the removal of impacted cerumen when the medical criteria and guidelines outlined in this policy have been met. Policy effective 07/01/2010.
12/21/10	Added “ear wax” for informational purposes in “Description” section. (btw)
6/12/12	The definition of impacted cerumen added to I. in the When Covered section for clarification. The following statement was added under the When Covered section to indicate; “II.5. A -25 modifier must be submitted with the E&M code for proper adjudication to indicate a significant, separately identifiable evaluation and management service was performed.” No change to policy intent. Medical Director review 5/28/2012. Reference added. (btw)
11/26/13	Routine review. No change to current policy. (adn)
1/1/2014	New information added to Billing/Coding section: Effective 1/1/2014 CPT 69210 describes a unilateral procedure. To report a bilateral procedure, append modifier -50 with “2” in the units field. (adn)
5/13/14	Policy category changed from “Corporate Medical Policy” to “Corporate Reimbursement Policy”. No changes to policy content. (adn)
10/30/15	Routine review. No change to current policy. (adn)
12/30/15	CPT 69209 added to the Billing/Coding section. (adn)
12/30/16	Routine policy review. The following statement was added to the Not Covered section: Cerumen removal is not covered when billed with audiologic function tests. Information added to the Billing/Coding section to states: Cerumen removal is considered incidental to audiologic function tests 92551 and 92552. (an)
12/29/17	Routine policy review. No change to policy. (an)
12/14/18	Routine policy review. No change to policy. (an)

1/14/20	Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)
12/31/20	Routine policy review. Medical Director approved 12/2020. No changes to policy statement. (eel)
4/20/21	Policy format update. No changes to policy statement. (eel)
12/30/21	Routine policy review. Medical Director approved. (eel)
12/31/2022	Routine policy review. Minor revisions only. (ckb)
01/17/2023	Clarified Billing and Coding section "*Cerumen removal is considered incidental to audiologic function tests"*. (cjw)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.