

Subject:	Removal of Impacted Cerumen		
Policy Number:	PO-RE-105v2		
Effective Date:	1/29/2019	Last Approval Date:	09/18/2026

I. Policy Description

The **removal of impacted cerumen (earwax)** refers to the extraction of hardened or accumulated earwax from the external auditory canal using mechanical techniques, such as irrigation, lavage, or debridement. While typically asymptomatic, cerumen buildup can interfere with hearing, patient comfort, and accurate diagnosis or treatment of otologic conditions.

The information below applies to the following lines of business:

• Child Health Plus (CHP)	• Essential Plan (EP)
• Integrated Benefit Dual Plan (IB-Dual)	• Managed Long Term Care Plan (MLTCP – Senior Health Partners)
• Medicaid Managed Care (MMC)	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicare Advantage HMO	• Qualified Health Plan (QHP)
• Medicare PPO	• Personal Wellness Plan (HARP)

Reimbursement Guidelines

Healthfirst does **not reimburse separately** for routine removal of cerumen. Cerumen removal using **softening drops, cotton swabs, or cerumen spoons** is considered part of the **Evaluation & Management (E/M)** or audiologic procedure performed during the same visit.

- Cerumen removal **is not reimbursed separately** when billed on the **same date** as an **E/M service** or **audiological function testing**.

1. This policy is applicable to the following codes: 69209, 69210, and G0268

Code	Description
69209	Removal of Impacted Cerumen Using Irrigation/Lavage, Unilateral

69210	Removal of Impacted Cerumen (Separate Procedure), One or Both Ears
G0268	Removal of Impacted Cerumen (One or Both Ears) by Physician on Same Date of Service as Audiological Function Testing

Billing Examples

Example 1: Non-Reimbursable Claim

- **Scenario:** Patient presents for routine hearing test. Provider removes cerumen using lavage to allow audiological exam.
- **Codes Billed:** 69209 and Audiological Test Code (e.g., 92557)
- **Outcome:** **69209 denied** as it is considered **inclusive** to the audiological service.

Example 2: Non-Reimbursable Claim

- **Scenario:** Patient presents with ear pain and impacted cerumen. Provider performs an evaluation and cerumen removal using debridement.
- **Codes Billed:** 69210, 99213 (E/M), Modifier **-25** on E/M
- **Outcome:** **69210 denied** as it is considered **inclusive to the E/M visit**.

Example 3: Incorrect Use of Code G0268

- **Scenario:** Provider performs cerumen removal and hearing test but bills **69210**.
- **Codes Billed:** 69210 and Audiological Test Code
- **Outcome:** **69210 denied**. Correct code when performed with hearing test is **G0268**.

Coding and Documentation Requirements

All coding must align with:

- CMS National Correct Coding Initiative (NCCI) guidelines
- AMA CPT® and HCPCS rules
- CMS and NYS Medicaid reimbursement policies
- Proper modifier use (e.g., Modifier -25 when appropriate)
- Accurate ICD-10 coding for medical necessity

Failure to adhere to coding and documentation standards may result in claim denial or recoupment.

Adjudication and Appeal Process

1. Reimbursement for the removal of impacted cerumen (earwax) services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.
2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.
4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.
5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17, "Billing & Claims Processing".*

Please be advised that all services provided are subject to the member's individual benefit coverage

II. Applicable Codes

Code	Description	Comment
69209	Removal of Impacted Cerumen Using Irrigation/Lavage, Unilateral	
69210	Removal of Impacted Cerumen (Separate Procedure), One or Both Ears	
G0268	Removal of Impacted Cerumen (One or Both Ears) by Physician on Same Date of Service as Audiological Function Testing	

III. Definitions

Term	Meaning
E/M Service	Evaluation and Management service.
Modifier -25	Indicates a significant, separately identifiable E/M service was performed by the same provider on the same day as another procedure.

IV. Related Policies

Policy Number	Policy Description
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N/A	N/A

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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

LCD - Cerumen (Earwax) Removal (L33945) (cms.gov)

VI. Revision History

Revision Date	Summary of Changes
9/18/2025	• Annual Review: Policy reviewed as part of the annual review process; no substantive changes to policy intent. • Adjudication Section: Updated the adjudication section to include standard organizational boilerplate language and messaging. • Line of Business Section: Updated the Line of Business (LOB) section to align with the organization's standard LOB language and format. Policy updated to include billing examples and clarify E/M bundling logic

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of

coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.