healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Removal of Impacted Cerumen		
Policy Number:	PO-RE-105v1		
Effective Date:	1/29/2019	**Last Approval Date:**	7/15/2024

I. Policy Description

The removal of impacted cerumen (earwax) is the extraction of hardened or accumulated cerumen from the external auditory canal by mechanical methods (irrigation or debridement). Though usually asymptomatic, the accumulation of cerumen can lead to other symptoms which can hinder the evaluation and management of other otologic conditions.

The information below applies to the following lines of business:

- Child Health Plus
- Small/Individual Group (Commercial Plan)
- Essential Plan
- Medicaid Managed Care
- Medicare PPO
- Integrated Benefits Dual Connection Plan
- Health & Recovery Plan (HARP)
- Medicare Advantage
- Medicaid Advantage Plus/MAP (Complete Care)
- Qualified Health Plan (QHP)
- Managed Long Term Care Partial Capitation Plan (MLTCP-Senior Health Partners SHP)

Reimbursement Guidelines

1. Healthfirst will not reimburse for the removal of impacted cerumen separately. The routine removal of cerumen (by use of softening drops, cotton swabs, or cerumen spoons) is considered part of the procedure with which it is billed (i.e., audiological function testing) and is therefore considered inclusive of the office visit. As such, it is not reimbursed separately on the same day as an Evaluation and Management (E&M) service. This decision relates solely to reimbursement for this procedure and does not pertain to individual member coverage.

2. 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

3. Payment may be made for both removal of impacted cerumen and an Evaluation and Management (E/M) service only if the E/M service represents a medically necessary, significant, and separately identifiable **service that is** supported by medical record documentation.

4. Corrected claim 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 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

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
N/A	N/A

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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

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.