Payment Policy: Cerumen Removal

Reference Number: CC.PP.008
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 11/21/2024

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Cerumen, or earwax, is produced in a regular and organic manner. It acts as a barrier against water and insects and shields the ear from infection. Though cerumen usually falls out of the ear canal on its own, it can occasionally get impacted.

A curette, alligator forceps, or a metal or plastic loop or spoon may be used to remove cerumen. Certain devices feature tips that are illuminated to enhance visibility while doing the process. Skills from a physician may be needed for extractions that are simple.

The purpose of this policy is to define separate payment criteria for removal of impacted cerumen to be used by the Health Plan in making payment decisions and administering benefits.

Application
This policy applies to all products.

Policy Description
Cerumen, or earwax, is the product of desquamated skin mixed with secretions from the adnexal glands of the external ear canal. It provides lubrication, acts as a vehicle for the removal of contaminants away from the tympanic membrane and prevents desiccation of the ear canal.

Though usually asymptomatic, cerumen can accumulate and become impacted causing such symptoms as conductive hearing loss, pain, itching, cough, dizziness, vertigo, and tinnitus. Impacted cerumen can also impede the evaluation and management of other otologic conditions.

Impacted cerumen may often be removed by simple irrigation with a bulb syringe, with or without chemical softeners, or removal by Q-tip or cotton-tipped applicator, and generally does not require a physician's skill. Some cases may require use of forced irrigation with a metal hand-held syringe or an electric oral jet irrigator. Others may need manual disimpaction under direct vision using suction, probes, forceps, hooks, wire loops, or other instruments.

Removal of impacted cerumen will require a physician's skill when removal by an individual other than a physician or qualified non-physician practitioner poses an unacceptable risk of complications, such as tympanic membrane perforation. Cerumen removal requiring a physician's skill may include cases where the tympanic membrane cannot be observed (e.g., total occlusion or impaction), there are overt medical contraindications such as anatomical abnormalities, surgical modifications, or risk of infection, presence of medical conditions that pose undue risk of excessive bleeding (e.g., use of anticoagulants), or the cerumen cannot be removed safely without undue risk of abrasion, laceration, or tympanic membrane perforation.

Reimbursement
In clinical situations when documentation demonstrates that the services are rendered in need of a physician's expertise, billing, and payment under CPT code 69210 or HCPCS code G0268 are restricted. Routine removal of asymptomatic, non-impacted, non-obstructive cerumen does not typically require a physician's skill and therefore is not paid alone or in conjunction with an E/M service.

Separate payment may be made only for:
1. Removal of symptomatic impacted cerumen;
2. Removal of impacted cerumen impeding the physician's ability to properly evaluate or manage other signs, symptoms or conditions (e.g., examination of the tympanic membrane in cases of otitis media); or
3. Removal of impacted cerumen impeding a physician's or audiologist's ability to perform covered audiometry.

In cases when cerumen removal is accomplished solely by irrigation or lavage (CPT 69209) and is not affected by instrumentation, payment for the service is included in the amount paid for the appropriate Evaluation and Management (E/M) service code that is billed on that day.

If documentation indicates that the patient had cerumen impaction and the removal required physician work and instrumentation such as wax curettes, forceps and/or suction rather than simple lavage (69209), modifier -59 may be appended to procedure 69210 to indicate that a distinct procedural service was performed.

An E/M service may not be billed in addition to the cerumen removal when the visit is exclusively for the medically necessary removal of symptomatic impacted cerumen.

Visualization aids, including but not limited to binocular microscopy, are covered under the reimbursement for HCPCS code G0268 and CPT code 69210 and should not be paid separately.

Utilization
If the removal of impacted cerumen is combined with an Evaluation and Management service performed on the same day, it cannot be billed unless the documentation supports the services being a significant, individually identifiable service on the same day.
For example:
- If the patient has pain in the external ear as his/her only complaint and the removal of cerumen addresses that complaint, one should bill only for removal of the cerumen, CPT code 69210.
- If the patient also has symptoms of otitis media requiring further evaluation, then it may be justified to also bill for an E/M service with Modifier 25 attached to the E/M service.

Billing for HCPCS code G0268 should only occur in situations when a doctor's expertise is required to remove affected cerumen on the same day as an audiologist employed by the doctor performs audiologic function testing. Since cerumen removal is regarded as a component of diagnostic testing and is not compensated independently, this code shouldn't be used when the audiologist removes the cerumen.

Documentation Requirements
Documentation should describe the degree of cerumen impaction, procedure performed, instrumentation used, and the name and professional credentials of the performing provider.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
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

Modifier	Descriptor
25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service
59	Distinct Procedural Service
XE	Separate Encounter
XP	Separate Practitioner
XS	Separate Organ/Structure
XU	Unusual Separate Service

Related Policies
- CC.PP.013 – Clinical Validation of Modifier -25
- CC.PP.014 – Clinical Validation of Modifier – 59

References
1. *Current Procedural Terminology (CPT®)*, 2025
2. *HCPCS Level II*, 2025

3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2025
4. https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf

Revision History	
08/015/2016	Added CPT code 69209 to address removal of impacted cerumen using irrigation/lavage technique. CPT code 69209 is a new code effective 1-1-2016.
02/06/2017	Converted to new template, added related policies and conducted annual review.
02/28/2018	Verified codes, conducted review, updated references
04/01/2019	Verified codes, conducted review, updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual Review completed; no major updates required
12/01/2022	Annual Review completed; no major updates required
02/26/2024	Annual Review completed; Updated Policy Overview, Policy Description, Reimbursement Description and Utilization description. Modifier 59 and -X modifiers updated with correct descriptors for each. Updated year and links.
11/21/2024	Annual Review completed; no major updates required

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.