Impacted Cerumen

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Q. When a patient comes in with ear pain due to impacted cerumen, the health-care provider would normally instruct the nurse to perform ear irrigation. If the irrigation successfully removed the impacted cerumen, the procedure would be considered part of any evaluation and management (E/M) service and we could not bill for the service separately. With new rules regarding cerumen removal this year, can we get reimbursed for the ear irrigation if it is not performed by the provider?

A. You are correct that prior to January 1, 2016, you would have had to report the ear irrigation as part of the E/M code if instrumentation was not needed to perform the procedure. The American Medical Association introduced *Current Procedural Terminology* (CPT) code **69209**, "removal impacted cerumen using irrigation/lavage, unilateral," to rectify that situation. The provider must still document that the cerumen was impacted in order to bill for the service, but removal does not have to be performed by a physician. The Medicare Physician Fee Schedule (MPFS) has assigned professional component (PC) and technical component (TC) indicator **5** to this code. This indicator means that the service is covered incident to a physician's service when the service is provided by auxiliary personnel employed by the physician and working under the physician's direct personal supervision. You may not bill CPT code **69209** with CPT code **69210**, "removal impacted cerumen requiring instrumentation, unilateral," for the same ear. However, CPT codes **69209** and **69210** can be billed for the same encounter if impacted cerumen is removed from one ear using instrumentation and from the other ear using lavage. You will bill each code with the appropriate **-RT** (right) and **-LT** (left) modifiers.

Both of these CPT codes are listed as unilateral services, and CPT guidelines instruct us to append modifier **-50**, "bilateral procedures that are performed at the same session," if one of the procedures is performed on both ears. However, the Centers for Medicare & Medicaid Services (CMS) treats these codes differently from what is in the guidelines. It has assigned a Medically Unlikely Edit (MUE) value of 2 to CPT code **69209** and MUE value of 1 for CPT code **69210**. An MUE is defined as the maximum units of service (UOS) that a provider would report for a procedure under most circumstances for a single beneficiary on a single date of service. This means that even though the physician may remove cerumen using instrumentation for both ears on the same date of service, CMS will reimburse you for only one instance, so you should not use modifier **-50**. Because the MUE for CPT code **69209** is 2, you would append modifier **-50** to report that the ear lavage was performed in both ears if both ears had impacted cerumen.

CMS limits payment for CPT code **69210** to earwax removal during visits that meet all of the following criteria:

- Cerumen removal is the only reason for the visit.
- Cerumen removal is performed personally by a physician or advanced practice provider.
- The patient is symptomatic (has pain, pressure, poor hearing, etc.) from excessive cerumen.
- Cerumen removal requires more than drops, cotton swabs, and a cerumen spoon.
- Documentation in the patient record shows that the procedure required significant time and effort.

CPT code **69210** will be reimbursed at around U.S.$50, and CPT code **69209** will be reimbursed at around U.S.$12, depending on the payor and your Medicare Administrative Contractor (MAC) jurisdiction.

When billing CPT codes **69209** and **69210**, report *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) codes:

- **H61.21**, "impacted cerumen, right ear"
- **H61.22**, "impacted cerumen, left ear"
- **H61.23**, "impacted cerumen, bilateral"

You may also report an E/M service if it is a medically necessary, significant, and separately identifiable procedure that is supported by medical record documentation.

Review payor contracts to determine rules for reimbursement

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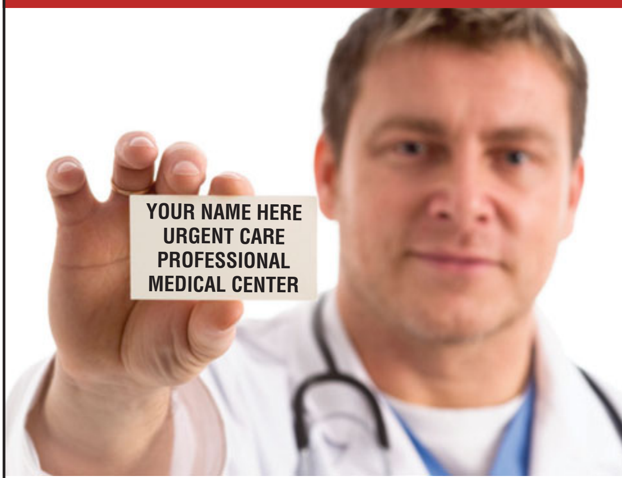

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CODING Q & A

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of these services. Most payors have adopted CMS requirements for reimbursement. Also look for local coverage determinations (LCDs) in your MAC jurisdiction for specific guidelines when billing CMS for these services, because they are more stringent than CPT guidelines, especially when it comes to reporting an E/M service with the cerumen removal. ■

Q. What are the criteria used to define impacted cerumen?

A. To meet the CMS definition of impacted cerumen, the physician must observe and document at least one of the following conditions in the chart:

- **Significant obstruction of the canal:** Cerumen impairs examination of clinically significant portions of the external auditory canal, the tympanic membrane, or a middle ear condition
- **Bothersome symptoms:** Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, and hearing loss
- **Inflammation:** Associated with foul odor, infection, or dermatitis
- **Difficult removal:** Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring a physician's skills

Because almost all patients requiring cerumen irrigation have significant obstruction of the canal (first criterion listed above), almost all cases requiring cerumen irrigation meet the CMS definition of impacted cerumen. ■

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