Cerumen or earwax is a yellowish wax-like secretion from the glands in the ear canal. Cerumen impaction is the deposit of wax in the ear leading to blockage of the ear canal. It needs expert hands for removal in pediatric patients. The removal is reported by the code 69210 (Removal impacted cerumen requiring instrumentation, unilateral). Before billing 69210, you need to get your facts correct to avoid a denial or the risk of an audit. Here are the points you need to look for:

1. **Check If Wax Meets Impaction Criteria**
   You can only report 69210 with a diagnosis of impacted cerumen (380.4). Removing wax that is not impacted does not justify 69210. Instead, capture this work with an E/M code (99201-99215, Office or Other Outpatient Services) — no matter how the provider removes the wax.
   To determine if documentation supports 380.4, use the definition from the American Academy of Otolaryngology-Head and Neck Surgery (AAOHNS). According to AAOHNS, consider cerumen clinically "impacted" if any one or more of the following are present:
   - **Visual considerations:** Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
   - **Qualitative considerations:** Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.
   - **Inflammatory considerations:** Associated with foul odor, infection, or dermatitis.
   - **Quantitative considerations:** Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.

2. **Use 69210 When Chart Contains 5 Points**
   The AAOHNS and AMA indicate 69210 also require physician performance and instrumentation. You may report removal with 69210 if performed by a physician using, at minimum, an otoscope and instruments, such as wax curettes or an operating microscope and suction, plus specific ear instruments (for instance, cup forceps and right angles).
   The following scenario would warrant the use of 69210: The patient presents to the office for an ear ache. Removal of impacted cerumen is required to visualize the tympanic membrane. The impacted cerumen is removed by the pediatrician with magnification provided by an otoscope and a wax curette.
   Code 69210 may be used here because both criteria were met: The patient had cerumen impaction (impairing examination of the tympanic membrane) and the removal required physician work using an otoscope and instrumentation rather than simple lavage.
   Code 69210 is a surgical procedure. Accompanying documentation should report the time, effort, and equipment needed to perform the procedure. Documentation must include the following:
   - The fact that cerumen impaction was observed, along with the location(s)
   - The instrumentation used (and any magnification)
   - The removal procedure
   - The procedure's outcome
   - Patient care instructions.

3. **Absent Instrumentation? Use E/M, Not 69210**
   Consider ear lavage, which is sometimes confused with cerumen removal, as part of an E/M visit (99201-99215). A nurse can provide the wash. There is no specific code for lavage including water picks. According to the AAOHNS and the AMA, the following scenarios do not justify the use of 69210, despite the significant medical assistant/nursing time and practice expense involved.
   **Patient scenario 1:** The patient presents to the office for the removal of earwax by the nurse via irrigation or lavage. This service is captured by the appropriate E/M code.
   **Patient scenario 2:** The patient presents to the office for the removal of earwax by the primary care physician via irrigation or lavage. This service is also captured with the appropriate E/M code.
   Ear irrigation or ear lavage without any separate provider use of instrumentation should be included in the E/M service.
selected for that day. The work performed should be appropriately documented - no matter which staff member provided the service. Appropriate documentation will allow the provider to include the work in his/her E/M selection.

4. Lavage + Instrumentation Requires 2 Notes

Heads up: If both ear lavage and instrumentation with an ear curette by the physician are required to remove the cerumen, it is appropriate to code 69210 for the procedure.

Tip: Always provide separate documentation for the impacted cerumen removal procedure. Do not bury it in the E/M note. Coding also requires modifier 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) on the associated E/M code.

5. Look to Modifier 50 When Warranted

Although most payers specifically indicated that practitioners had to use instrumentation when removing impacted cerumen to qualify for 69210, CPT 2014 confirms that lead and puts it right in the code description, with the full descriptor now stating, “Removal of impacted cerumen requiring instrumentation, unilateral.” Therefore, using ear lavage, water pick or ear washings will not qualify for 69210 because they don’t qualify as instrumentation (instead, items like earwax curettes are considered instrumentation). In addition, this change reminds you that need to append a bilateral modifier (modifier 50) to 69210 when removing cerumen from both ears.

Some More On Cerumen Impaction

1. E/M needs documentation to go with 69210

Cerumen removal is not simple earwax removal and it can be real tricky for your practice, particularly if the physician performs the service as a gateway to visualize the ear. The following examples will make it easy for you to know when to report 69210 (Removal impacted cerumen requiring instrumentation, unilateral) and get paid for it.

Example: Patient presents with ear pain. The physician finds out impacted cerumen needs to be removed to access the tympanic membrane. Final diagnosis is an ear infection. Could you bill an office visit and modifier along with 69210?

Key: You cannot bill 69210 if the physician just flicked a little wax aside to visualize the tympanic membrane. The physician uses special device that allows to curette the ear for visualizing the tympanic membrane. According to the July 2005 CPT® Assistant, cerumen is considered “impacted” in several circumstances, eg, cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition. If the physician is not able to view these areas of ear due to cerumen blockage and he/she needs to use special instrumentation to remove it above and beyond irrigation, you can report 69210 and most payers will readily pay for it. Ensure you have separate documentation of the E/M service and procedure to support reporting both codes. But accept the fact that some insurers still may not pay for it.

Modifier advice: Never forget to append modifier 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) with 99201-99215 (Office or other outpatient visit for the evaluation and management of an established patient ...) when reporting along with 69210. Include diagnosis 380.4 (Impacted cerumen) on the 69210 claim, and an ear-related diagnosis (such as 382.00) on the E/M line item. Ensure your physician has sufficient documentation for the cerumen removal.

2. Don’t Consider Cerumen Removal Code When it ‘Falls Out’

Here is one example of insufficient documentation.

Example: The physician extracts a jewelry bead from a four-year-old patient’s ear and removes cerumen with the bead. The documentation states that the bead was embedded in the ear canal, adjacent to the eardrum posteriorly. This was carefully removed using alligator forceps, and cerumen was withdrawn from the ear with the bead. Should you report 69210 in this instance?

Solution: This documentation is not enough to support a 69210 claim, since it states that the ear wax simply came out along with the bead. Your best bet is to report the foreign body removal only (69200, Removal foreign body from external auditory canal; without general anesthesia).

3. When Treating Ear Pain, Match Coding to Final Diagnosis

Don’t always get attached to the presenting diagnosis on a chart, the pediatrician might have found a more definitive diagnosis during the visit. Ideally, you should expect the pediatrician to provide the definitive diagnosis.

Example: A toddler is brought to your office by his father because of ear pain and the pediatrician diagnoses earache with acute otitis media. Should you report the earache with the otitis media? No, because earache is inherent to acute otitis
Acute suppurative otitis media without spontaneous rupture of ear drum.
You should only code the confirmed or definitive diagnosis(es) when you have them documented in the interpretation and you don't need to code related signs and symptoms additionally.
But if the earache is the only condition the physician could report, then go for it (388.70, Otalgia).

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