ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Impacted Cerumen Removal-GA MCD-AD-1259	03/01/2025-01/31/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Impacted Cerumen Removal

B. Background

Cerumen or ear wax is a naturally occurring substance that cleans, protects, and lubricates the ear canal. The cerumen can block the ear canal causing symptoms such as pain, hearing loss, fullness, itching, and tinnitus. Methods for removal of cerumen include irrigation, manual removal with instrumentation, and cerumenolytic agents. Cerumen removal may require a physician when methods such as irrigation or removal by cotton-tipped applicators are not sufficient.

C. Definitions

- **Cerumen Impaction** – An accumulation of cerumen that is associated with symptoms and/or prevents a necessary ear examination.
- **Modifier** – Two-character code used along with a CPT or HCPCS code to provide additional information about the service or procedure rendered.
- **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.
- **National Correct Coding Initiative (NCCI)** – A program developed by CMS to promote national correct coding and to prevent improper payment when incorrect code combinations are reported.

D. Policy

I. Claims submission for cerumen impaction should include the appropriate CPT code and ICD-10, such as

A. ICD-10

1. impacted cerumen, unspecified ear
2. impacted cerumen, right ear
3. Impacted cerumen, left ear
4. impacted cerumen, bilateral

B. CPT

1. removal impacted cerumen using irrigation/lavage, unilateral
2. removal impacted cerumen requiring instrumentation, unilateral
3. removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing

NOTE: Visualization aids, such as, but not limited to, binocular microscopy, are considered included in the CPT code and should not be billed separately.

II. Evaluation and management (E&M) visit

A. Impacted cerumen

1. An E&M service may not be billed when the sole reason for the visit is to remove symptomatic impacted cerumen.

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2. An E&M service on the same day as removal of impacted cerumen may not be billed unless it represents and is documented to be a significant, separately identifiable service on the same day.

B. Non impacted cerumen
For removal of cerumen that is not impacted, use the E&M service code.

III. Modifiers
A. Use modifier 25, and/or 50, when appropriate.
B. Follow NCCI guidelines and use appropriate modifiers, as applicable.
C. For bilateral procedures, use Centers for Medicare & Medicaid Services (CMS) guidelines.
D. Separate payment is only justified when modifier 25 is appended indicating the following:
1. removal of symptomatic impacted cerumen
2. impacted cerumen impeding a physician's ability to properly evaluate or manage other signs, symptoms, or conditions or
3. impacted cerumen impeding a physician's or audiologist's ability to perform covered audiometry

NOTE: Documentation confirming impacted cerumen and justification of the use of modifier 25 must be submitted with the claim to support medical necessity.

E. Conditions of Coverage
NA

F. Related Policies/Rules
Modifier 25 Reimbursement

G. Review/Revision History

	DATE	ACTION
Date Issued	10/26/2022	New Policy.
Date Revised	10/11/2023 10/09/2024	Per Program Integrity, removed modifier 59. Updated references. Approved at Committee. Updated references. Approved at Committee.
Date Effective	03/01/2025	
Date Archived	01/31/2026	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References
1. Local Coverage Determination: Cerumen Removal. Medicare Coverage Database; 2015. LCD ID L33945. Revised February 1, 2024. Accessed August 28, 2024. www.cms.gov
2. Schwartz SR, Magit AE, Rosenfeld RM, et al. Clinical practice guideline (update):

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

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earwax (cerumen impaction). *Otolaryngol Head Neck Surg*. 2017;156(1_suppl):S1-S29. doi:10.1177/0194599816671491

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