CareSource

MEDICAL POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Date Effective
Impacted Cerumen Removal		MM-1033	11/01/2021-07/31/2022
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Administrative Policy Statements 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 normal 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 to removal the cerumen include irrigation, manual removal with instrumentation, and cerumenolytic agents.

C. Definitions

- **Cerumen Impaction –** An accumulation of cerumen that is associated with symptoms and/or prevents a necessary ear examination.

D. Policy

I. Impacted cerumen removal is covered when performed by a physician or other qualified health care professional such as a nurse practitioner, a physician assistant, or a clinical nurse specialist in the following circumstances:
   A. An accumulation of cerumen is seen on otoscopy and
      1. Is associated with symptoms;
      2. Prevents ability to manage or evaluate other signs, symptoms, or conditions; or
      3. Impedes ability to perform a medically necessary audiometry.

II. It is not recommended to routinely treat cerumen when members are asymptomatic, and ears can be adequately examined.

III. Documentation must include the following as applicable:
   A. Degree of cerumen impaction
   B. Method of removal
   C. Instrumentation used
   D. Resolution of impaction
   E. Additional treatment provided
   F. Referrals
   G. Name and professional credentials of provider

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Impacted Cerumen - OH MCD - AD - 1059

Archived

G. Review/Revision History

	DATE	ACTION
Date Issued	07/22/2020	New Policy
Date Revised		Removed "no prior authorization needed." Added CMS reference. Referenced AD-1059
Date Effective	TBD	
Date Archived	07/31/2022	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. Centers for Medicare & Medicaid Services. Local Coverage Determination Cerumen Removal L33945. (2021, February 4). Retrieved June 24, 2021 from www.cms.gov.
2. Schwartz, S., Magit, A., and Rosenfeld, R. (2017, January 3). Clinical Practice Guideline (Update): Earwax (Cerumen Impaction). 156(1). Suppl. 2017 S1-S29. https://doi.org/10.1177/0194599816671491

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

Independent medical review – 7/2020

Archived