Cerumen Removal

Reimbursement Policy ID: RPC.0108.01CH

Recent review date: 08/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines the reimbursement the health plan guidelines for the removal of impacted cerumen (ear wax).

Exceptions

N/A

Reimbursement Guidelines

Impacted cerumen removal is the mechanical extraction of impacted or hardened ear wax from the external ear canal, by irrigation or debridement.

The simple removal (e.g., with cotton swabs or softening drops) of cerumen is included in the Evaluation and Management (E/M) service and is not generally separately reimbursable. However, if the diagnosis supports the separate removal of the cerumen, then it may be reimbursed in addition to the E/M reimbursement.

Reimbursement consideration for cerumen removal in addition to payment for the E/M will be made when the below criteria are met:

- A separate complaint of ear pain, discomfort etc., is relayed by the patient or found by the provider on exam.
- The diagnosis reported with the E/M is unrelated to cerumen removal.
- Modifier 25 is applied correctly to indicate a significant, separately identifiable E/M service.
- Documentation in the medical record supports separate reimbursement of the cerumen removal procedure and the E/M services.

If the sole reason for the encounter is for the removal of the cerumen, a separate E/M service is not reimbursable.

CPT and Diagnosis
CPT codes for the removal of cerumen are based on how the cerumen was removed. See codes and descriptions below:

CPT code	Description
69209	Removal impacted cerumen using irrigation/lavage unilateral
69210	Removal impacted cerumen requiring instrumentation unilateral

CPT codes 69209 and 69210 are for unilateral anatomic sites. When performed unilaterally, the claim must include the corresponding anatomical modifier. For example, if the provider removes impacted cerumen by lavage in the left ear, the claim should reflect code 69209-LT. Using the same example, If the removal of cerumen is performed on both sides (bilateral), the code would need to be submitted with the 50 modifier 69209-50.

The diagnosis on the claim must support the reason for the cerumen removal.

Diagnosis Code	Description
H61.21	Impacted cerumen, right ear
H61.22	Impacted cerumen, left ear
H61.23	Impacted cerumen, bilateral

Definitions

Cerumen Impaction
Cerumen impaction is a condition in which earwax, or cerumen, becomes tightly packed in the external ear canal, blocking it. This can happen when the ear's self-cleaning mechanism fails.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)

VI. American Academy of Otolaryngology – Head and Neck Surgery – CPT for ENT: Cerumen Removal https://www.entnet.org/resource/cpt-for-ent-cerumen-removal-2
VII. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

RPC.0006.01CH Bilateral Procedures
RPC.0009.01CH Significant-Separately Identifiable Evaluations and management Service Modifier 25
RPC.0026.01CH National Correct Coding Initiative (NCCI)

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
08/2026	Reimbursement Policy Committee Approval
07/2026	Annual update • No major changes
03/2026	Updated to remove primary from the supporting diagnosis
10/2025	Reimbursement Policy Committee Approval
09/2025	Annual update • No major changes
06/2025	Minor updates to formatting and syntax
06/2025	Reimbursement Policy Committee Approval