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Internal Medicine Coding Alert

ICD-10: Impacted Cerumen Coding: Physicians to Note 'Right' or 'Left' for ICD-10

The H61.2- family will have all your code choices.

You know that certain requirements must be met before you can report removal of impacted cerumen, but don't overlook the associated diagnoses. Once ICD-10 goes into effect, you'll need to pay closer attention to physician documentation to ensure you report the service correctly.

Get Familiar With the Causes

Impacted cerumen (or wax in the ear) can affect both children and adults. The condition occurs when layers of wax within the ear canal build up to the point of blocking the canal and putting pressure on the eardrum. Cerumen is most likely to become impacted when it is pushed against the eardrum by objects people put in their ears, or when it is trapped against the eardrum by a hearing aid. Less common causes include an overproduction of earwax or an abnormally narrow ear canal that tends to trap the wax.

Symptoms: Partial loss of hearing is the most important symptom of cerumen impaction. Other symptoms can include itching, tinnitus (noise or ringing in the ears), a sensation of fullness in the ear, and pain in the ear (otalgia). In very young children, cerumen impaction is sometimes discovered during a routine check-up when the doctor finds that the earwax is blocking his or her view of the eardrum.

Prepare for Right/Left Specifications

ICD-9 currently provides a single diagnosis code for impacted cerumen: 380.4 (Impacted cerumen). Coding guidelines instruct you to report an additional external cause code, if applicable, to identify the cause of the ear condition.

"Typically, when ICD-9 refers to an 'external cause code,' it's referring to an E code," says **Kent J. Moore,** manager of healthcare delivery and finance systems for the American Academy of Family Practice (AAFP) in Leawood, Kan. "In general, most external cause codes aren't applicable to impacted cerumen. The only one that might be applicable is E013.8 (Activities involving personal hygiene and household maintenance; other personal hygiene activity)."

"If the impacted cerumen was the result of someone trying to clean his or her ear out with a Q-tip, you might be able to list E013.8 as an external cause," Moore adds. "That said, most times an external cause code won't be needed or applicable."

ICD-10 change: Documentation and your resulting diagnosis coding will need to be more specific under ICD-10. You'll find your choices in the H61.2- (Impacted cerumen) series of codes. The fourth digit will specify the affected ear:

- H61.20, Impacted cerumen, unspecified ear
- H61.21, Impacted cerumen, right ear
- H61.22, Impacted cerumen, left ear
- H61.23, Impacted cerumen, bilateral.

The procedure: Physicians typically diagnose impacted cerumen by examining the patient's ear canal and eardrum with an otoscope. Irrigation is the most common method of removing impacted cerumen; the process involves washing out the ear canal with water from a commercial irrigator or a syringe with a catheter attached.

If irrigation is not an option or if it fails to remove the cerumen, the physician can remove the wax with a vacuum device

or curette (a small, scoop-shaped instrument). The physician uses the curette to ease the impacted wax away from the sides of the ear canal. This ear wax removed by the physician using instrumentation and direct visualization is consistent with CPT® code 69210 (Removal impacted cerumen [separate procedure], 1 or both ears) for the procedure. This code cannot be used for irrigation only.

Future coding: Physicians will need to be more detailed in their documentation of impacted cerumen by noting which ear is affected and how they treated the problem. Let your physicians know that they need to include details regarding which ear has impacted cerumen, so you don't have to report the "unspecified" diagnosis.