Codify
BY AAPC

Internal Medicine Coding Alert

You Be the Coder: Clearing Cerumen for Ear Exam

Question: Our internist performed removal of cerumen by irrigating the ears of a patient to examine the ears. In the documentation, there is no mention of impaction of the cerumen. Can I report a cerumen removal code if there was no impaction of the cerumen?

New York Subscriber

Answer: When your internist performs removal of cerumen from the ear by irrigation or lavage, you may report the procedure using the CPT® code 69209 (Removal impacted cerumen using irrigation/lavage, unilateral). However, you can report the code only if the cerumen was impacted and not otherwise. The inclusion of "impacted cerumen" in the code descriptor and a parenthetical note after the code reinforce this point.

You cannot report 69209 if your clinician performed removal of the cerumen because the patient requested for a clean-up of the ears. Also, you cannot report the code when your clinician performed the procedure to clear the ears for the purpose of examining the ears; in that situation, the irrigation or lavage is generally considered part of the more extensive procedure (the exam). As this seems to be case in the scenario you have elaborated, you cannot report the removal of the cerumen with 69209.

If cerumen was removed by irrigating or lavage and you cannot separately report it with 69209 (for example, because the cerumen was not impacted), the work will just be included in the E/M code that you are reporting for the encounter.