Internal Medicine Coding Alert

Incision and Drainage: Inability To Document Complicated I&D Could Result In $90 Loss

Watch for instances when you can report an additional E/M.

When your clinician performs an incision and drainage (I&D) of a cyst or abscess, you should be aware of identifying a complicated drainage procedure from a simple I&D. You should also know when to report an E/M code separately, or you will lose out on deserved reimbursement.

When your internist performs an incision and drainage of an abscess, you have two CPT® codes to choose from to report the procedure depending on the complexity of the procedure performed:

- 10060 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single)
- 10061 (...complicated or multiple)

Reimbursement: The 2015 relative value units (RVUs) for 10060 are 3.31 while 10061 carries 5.85 RVUs. This translates to a Medicare reimbursement of $118.35 for 10060 and $209.16 for 10061. As the difference in reimbursement is approximately $90 between the two codes for I&D of an abscess, you risk losing a whopping sum if you make an error in identifying between simple and complicated.

Learn to Differentiate Between Simple and Complicated I&D

As you risk losing a major amount of money if you make the mistake of reporting a simple I&D procedure instead of a complicated I&D, you should know how to clearly identify when to report 10060 and 10061. For you to be able to do this, you should be able to identify when the procedure is complicated and when it is just a simple incision and drainage procedure that your physician performed.

You report 10060 for a simple I&D procedure and for incision and drainage procedure of an individual lesion. A simple I&D will involve drainage of an abscess that is present in the superficial layers of the skin. This will involve usually the dermis, epidermis, or the subcutaneous layers of the skin and will not have any deeper or extensive involvement. When your physician drains a simple abscess, he will usually make a simple incision that will drain the pus present in the abscess.

Example: Your internal medicine provider reviews a 23-year-old male patient who complains of severe pain and tenderness in the area of the thigh of the right leg. The patient says that he had an injury three days prior when he scraped his leg against a sharp edge of a wooden stool. Upon examination, your clinician notes that the area is red, swollen, and appears to be filled with pus. Your clinician makes an incision using a No.11 scalpel and drains the pus from the wound. Your internist then irrigated the wound and placed a dressing.

What to report: Since your physician drained a simple, superficial abscess, you report 10060 for the I&D procedure. You also report the ICD-9 code, 682.6 (Cellulitis and abscess of leg except foot) to report the diagnosis of an abscess of the thigh area. You report L02.415 (Cutaneous abscess of right lower limb) if you are using ICD-10 codes to report the diagnosis.

I&D of complicated abscess: You report 10061 when your internist drains a complicated abscess or multiple abscesses. The size of the abscess might not give an indication about the complexity or complication but depth of infection might help. Your clinician might use a local anesthetic to numb the area prior to performing the I&D. Also, a complicated I&D will involve treating an abscess that contains many loculations, which will need extensive probing by

your clinician to drain completely. Your clinician might also use packing when performing an I&D of a complicated abscess. Alternatively, you will also use 10061 when you are reporting incision and drainage of multiple, simple abscesses.

"Current Procedural Terminology (CPT®) does not define 'simple' or 'complicated' with respect to codes 10060 and 10061," notes **Kent Moore,** senior strategist for physician payment at the American Academy of Family Physicians. "From a CPT® perspective, the choice of code is at the physician's discretion, based on the level of difficulty involved in the procedure," adds Moore.

Example: Your physician reviews a 56-year-old male patient with complaints of pain and swelling in the area of the wrist on the left hand. He says that the pain started about two days ago, and he does not remember any injury to the area. Upon examination, your physician notes an approximately 3 cm swelling in the area of the wrist that appears to be filled with pus. Your clinician numbs the area with a local anesthetic, then performs a single incision using a No. 11 scalpel blade. He then drains the pus and then probes into the area to break up some loculations that drain out more pus. He then irrigates the area and packs the wound with gauze.

What to report: Since your physician probed the abscess to break up loculations and packed gauze, the I&D does not appear to be simple, and you may report the I&D with 10061. You report the diagnosis with 682.4 (Cellulitis and abscess of hand except fingers and thumb) if you are using ICD-9 codes or report L02.512 (Cutaneous abscess of left hand) when using ICD-10 codes.

Know When to Report an Additional E/M Code

When you report an I&D procedure with either 10060 or 10061, you should not report an additional E/M code with the procedural code as a norm. Most of the preliminary evaluation that your internist performs prior to the procedure will be included in the work described by the I&D code that you are reporting.

Also, Correct Coding Initiative (CCI) edits are in place that bundle an E/M code with the two I&D codes. However, the modifier indicator for these bundling edits is '1,' which means you can separately report both the E/M code and the I&D code if an appropriate modifier is used to break the edit.

However, you should not report the E/M code every time you are reporting an I&D code. You will only report an E/M code separately if and only if a separate and significant E/M service was performed that was in addition to the preliminary evaluation that your clinician performed. In such a case, you can report both the I&D code and the E/M code together. Since the E/M codes are the column 2 codes in the CCI edit pairs, you will have to append a suitable modifier with the E/M code that you are reporting. The modifier that you will have to use with the E/M code is 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).

"In general, significant and separately identifiable means the E/M service is over and above that typically associated with the procedure in question," points out Moore. "Ideally, the documentation of the separate E/M service would stand alone to justify reporting it in addition to the code for the I&D," he adds.

Example: Suppose in the example described above, if the patient had diabetes and your clinician investigated further to check his sugar levels to see if there is going to be any adverse problems due to his diabetes. Since your clinician performed an evaluation that is separate from the preliminary investigation that your clinician typically performs prior to the I&D, you will report this evaluation with an E/M code such as 99213 (Office or other outpatient visit for the evaluation and management of an established patient...) in addition to 10061.