Internal Medicine Coding Alert

Incision and Drainage Mythbuster: Avoid Denial Dilemmas on I&D Abscess

You'll get twice the payment when you know where to look.

Incision and drainage (I&D) services are covered for treating abscesses -- but recouping the maximum reimbursement is not as easy as you think. One wrong move could cost you as much as $80 reimbursement.

Do not let these 2 myths ruin your I&D abscess coding strategies.

Myth 1: I&D Codes Do Not Differ Significantly From Each Other

Reality: In fact, you'll discover just the opposite: these codes differ in a variety of ways.

For instance, complicated I&D code 10061 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; complicated or multiple) pays almost twice the reimbursement for superficial I&D code 10060 (... simple or single).

You'd be able to tell superficial from complicated with wounds that primarily involve the 'surface' layers of the skin -- the epidermis, dermis, or subcutaneous tissues, according to **Carol Pohlig, BSN, RN, CPC, ASC,** senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

Example: A patient with an upper arm mass that is red, warm, and tender comes for a visit. The internist performs a level-two E/M, and decides to do I&D. She numbs the area surrounding the injury, covers the abscess with antiseptic and drapes the site. She, then, opens and drains the abscess, covering the site with a bandage, and leaving it to heal on its own with wound care.

This procedure qualifies as a simple (superficial) I&D, which you should report with the following codes:

- 10060 for the I&D;
- 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making) for the E/M;
- modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) attached to 99212 to show that the I&D and E/M were separate services; and
- 682.3 (Other cellulitis and abscess; upper arm and forearm) representing the abscess, and as diagnosis for 10060 and 99212.

Report 10061 If Documentation Specifies Infection

Although you may think determining when to report complicated I&D will be difficult, rest assured: it's easy. Look for these two elements: multiple incisions are required, or the abscess is complicated by the presence of an infection, says Pohlig.

You could also turn to 10061 if the I&D takes an unusual length of time to finish, is especially deep, or requires drain placement, more extensive packing, or subsequent wound closure.

Example: The internist performs I&D on a patient with an infected forearm abscess. She incises to just above the cyst cavity and drains about 10 ml of foul-smelling pus. She removes the pus, and then excises the cyst wall from the

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surrounding tissue using electrocautery. She irrigates the wound with saline and places a drain in the cavity, and re-approximates the skin with two interrupted 3-0 nylon mattress sutures. Finally, she applies sterile gauze after cleaning and drying the skin.

Way out: This procedure falls under complicated I&D. On the claim, you should report 10061 for the I&D, and 682.3 (Cellulitis abscess upper arm forearm) linked to 10061 to represent the patient's cyst.

Payoff: You must know how to differentiate between the two I&D codes, or else you risk losing out on your reimbursement. Based on 2010 RVUs -- 2.81 for 10060 and 4.77 for 10061 -- the difference in payment is significantly high. Using the conversion factor of $36.8729, 10060 should pay about $88.86, while 10061 about $156.34.

Myth 2: Use I&D Codes Whenever Abscess Is Present

Reality: The presence of an abscess or cyst does not always require a surgical incision and drainage service. When pus is present in an abscess or cyst without a drainage outlet, then it is medically necessary to perform an incision and drainage.

Caution: You are likely to get denied on your claims for I&D services if the internist performs the procedure for drainage of a blister, particularly if the blister is small, uninfected, superficial and uncomplicated, according to healthcare reimbursement site AccuChecker.

Remember: Your physician's notes will need to support the complexity of the procedure, reminds **Elizabeth McDonald, CPC,** coding specialist in the department of surgery at UPMC-Pittsburgh. If blisters, cyst (including sebaceous cyst), cellulitis or other fluid collections and infections do not have documented presence of discrete abscess or pus collection, forget about reporting 10060-10061.

Note: When you code these procedures in conjunction with an initial hospital visit or a subsequent visit, for example, make sure you append modifier 25 to the E/M to point out that you are seeing the patient for multiple ongoing conditions.

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