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Internal Medicine Coding Alert

Quiz Answers: Read Experts' Input on Coding Scenarios

How many did you get right? Read on to find out.

Scenario 1: Simple vs. Complicated I&D

What to report: In this case scenario, you will have to report 10060 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single) for the incision and drainage of the abscess that your internist performed for the patient.

When your clinician performs an incision and drainage of an abscess, you report it either with 10060 or 10061 (...complicated or multiple). The 2016 total relative value units (RVUs) for 10060 in the non-facility setting (such as the physician's office) are 3.32 while 10061 carries 5.85 total RVUs in the same setting. This translates to a Medicare reimbursement of $118.87 for 10060 and $209.46 for 10061. Since there is a difference of approximately $90 between the two codes for I&D of an abscess, if there is a mistake in identifying between simple and complicated, it will translate into a substantial loss to your practice as you will be losing out on deserved pay.

Knowing the difference between simple and complicated I&Ds will help keep your reporting accurate. "The key to distinguish between simple and complicated will be found within the documentation by the physician," says **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, senior principal of ACE Med, a medical auditing, coding and education organization in Pittsburgh, Pa."She'll indicate length, depth, complexity, etc. Simple usually involves a small one time incision where complicated will involve more cuts, deeper, longer, more area, infection, etc."

Turn to CPT®10060 when your clinician performs an I&D of an abscess that is located in the superficial layers of the skin (dermis, epidermis, or subcutaneous layers) and does not have any deep extensions. When draining a simple abscess, your clinician will make a simple incision that will help drain out the pus.

On the other hand, you will report 10061 when the abscess is located deeper. You also report 10061 when your clinician had to spend more time than typical to drain out the abscess as the location of the abscess is complicated by presence of vital structures. Another instance where you can report 10061 is when the abscess contains loculations that need to be probed extensively to help drain the abscess. You can also report the complicated I&D code when your clinician is performing the I&D of more than one abscess. Another hint that will help you know when to report 10061 is when patient documentation mentions the use of packing, placement of drain, or performance of a layered closure of the incision site.

"From a CPT® perspective, the distinction between 'simple' and 'complicated' is ultimately a matter of judgment on the part of the physician," says **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "If in doubt about which code to choose in a particular case, you should consult with the physician who performed the procedure."

You should reserve the use of 10120 (Incision and removal of foreign body, subcutaneous tissues; simple) and 10121 (...complicated) only when your clinician is performing the incision to remove a foreign body from the subcutaneous tissues. Since in this case scenario, your clinician only performed incision and drainage and there is no mention of removal of any foreign body, you should not use either of these codes for this situation.

Scenario 2: Anatomical Site-Specific I&D Reporting

What to report: In this case scenario, you will report 25028 (Incision and drainage, forearm and/or wrist; deep abscess or hematoma) for the incision and drainage procedure that your clinician performed.

The CPT® codes 10060 and 10061 are not the only codes that you have to report an incision and drainage of an abscess. CPT® also has some site-specific codes that you can report when your clinician performs an I&D of an abscess that is

located in these specified sites. CPT® guidelines instruct you to report these site-specific codes (when available) instead of reporting 10060 or 10061.

Also, when you look at reimbursement for these site-specific codes, they earn you better reimbursement than what you will be paid if you are reporting 10060 or 10061. For instance, 25028 carries 14.95 total RVUs in the facility setting, which translates to a Medicare reimbursement of $535.27, while 10061 has only a payout of $209.46.

There are two site specific codes that you can choose from when your clinician performs an I&D in the wrist:

- 25028
- 25031 (...bursa)

Report 25031 when your clinician performs an I&D of the bursa. Since in the case scenario described, your clinician performed an I&D of an abscess deep in the wrist and not an I&D of an infection of the bursa, you should report 25028 and not 25031.

Scenario 3: Multiple Abscess I&D Reporting

What to report: In this case scenario, report 10061 for the I&D of the abscess in the upper arm and 10060 for the I&D of the abscess located in the chest area. Append the modifier 59 (Distinct procedural service) to 10060.

Since the descriptor to 10060 mentions the term "single," choose 10061 if your clinician is performing I&D of multiple simple abscesses. However, when your clinician performs a simple drainage of one abscess in one anatomical location and a complicated drainage of another abscess in another anatomical location, you can choose to report both 10060 and 10061 together.

However, when you look at Correct Coding Initiative (CCI) edits, you will see that the two codes for I&D carry an edit bundle. The modifier indicator to this edit bundle is '1,' indicating that the bundling can be overcome with the use of a suitable modifier. Since 10060 is the lesser paying procedure and the code in column 2 of the CCI edits, you will have to append the modifier to this code. The modifier that you will use with 10060 is 59.

Scenario 4: Repeat Procedure Within Global

What to report: In this case scenario, report 10060 with the modifier 76 (Repeat procedure or service by same physician or other qualified health care professional) for the repeat I&D procedure that your clinician performed.

Both the I&D codes, 10060 and 10061 carry a 10-day global period. Per CPT®, the surgical package includes "typical postoperative follow-up care." So, any follow-up procedures that your clinician performs typically during this 10-day period will normally be included, and you cannot make a separate claim for the service.

But, if your internist performed a repeat procedure, which is not a part of usual follow-up, you can report this procedure with another unit of 10060. "If your clinician performed a repeat within the global period, it would probably be denied initially and then would need to be reviewed with a detailed note from the surgeon," Hauptman says.

In order to let the payer know that your clinician repeated the procedure, you will have to append the modifier 76 (Repeat procedure or service by the same physician or other qualified health care professional) to the second unit of the code that you are reporting. This should not only allow you to get 100% reimbursement for the repeat procedure, it should also restart the global period for the procedure.

Modifier 76 is not restricted to procedures performed on the same day.

Instead of using modifier 76, you could use modifier 58 (Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period). Per CPT®, this modifier is used "to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure."

Since in the case scenario described, your clinician repeated the procedure within the global period of ten days, you can report a second unit of 10060 with the modifier 76 appended to the code.

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