Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: E/M or Burn Treatment?

Question: A patient was recently seen in our office because she had become dizzy while cooking, fell and burned her forearm on the stovetop. Should we use an office visit code to report the treatment of the burn?

Arizona Subscriber

Answer: In most instances, it would be better to report a burn treatment code (e.g., 16000-16025*). Unfortunately, many internal medicine practices use problem-oriented E/M codes (99201-99205 for new patients, or 99211-99215 for established patients), not recognizing that burn codes often result in higher reimbursement. According to the 2002 Physician Payment Schedule, the national Medicare average payment for a level-three established patient E/M service (99213) is $50.31, while payment for burn treatment 16020* (Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small) is $74.57.

However, in your case, it might also be appropriate to report both an E/M service and the burn treatment. Because the patient became dizzy before the fall, the internist will most likely assess the reasons for the dizziness as well as treat the burn. The physician may perform a neurological evaluation, for instance, or check for inner-ear problems. The appropriate E/M code should be assigned, depending on the extent of the history-taking, physical exam and level of decision-making. Because 16020 is a starred procedure meaning the code reflects the service provided, and no pre- or post-procedure care is included no modifier needs to be reported with the E/M code. If the procedure were not starred, modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) would be appended to the E/M code.

Link the appropriate dizziness diagnosis code (780.4, Dizziness and giddiness) to the E/M service. ICD-9 codes describing the burn should be mapped to 16020 or any other procedure code that accurately reflects treatment. Often, burn diagnoses include three separate codes. The primary diagnosis code is based on the location and the severity of the burn or burns being treated (941.x-945.x). The first three digits describe the general body area that is affected (e.g., 943, Burn of upper limb, except wrist and hand). The fourth digit indicates the severity of the burn, while the fifth digit specifies the exact location of the body part affected.

The second ICD-9 code that must be reported with burn treatment codes is 948.xx (Burns classified according to extent of body surface involved). Rather than telling payers which part of the body is injured, this code describes the severity of the burn.

Finally, most burn cases require an E code to explain the exact cause of the burn (e.g., E924.8, Accident caused by hot substance or object, caustic or corrosive material, and steam; other, heat from electric heating appliance). E codes are always secondary codes and may not be recognized by all payers. Check with insurers to determine their policy regarding E codes.