Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: Report Two Codes for Burn Treatments

Question: My internist recently treated a patient who had an episode of dizziness while cooking, fell and burned her forearm. Should we report a new patient office visit (99201-99205) for the burn treatment?

New York Subscriber

Answer: Because the patient had an episode of dizziness, you might want to report an E/M code (99201-99205) and a burn treatment code (16000-16025). In addition to treating the burn, your internist probably assessed the reasons the patient became dizzy. For instance, your physician probably performed a neurological exam or checked for inner-ear problems (388.7x). If that's the case, you could report 99202 (Office or other outpatient visit ... new patient), depending on your internist's documentation.

The burn treatment code you select also depends on your physician's documentation. If, for example, you assign 16020* (Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small), you will not need to attach a modifier to 99202. Burn code 16020 reflects the service provided and doesn't include any pre- or postprocedure care. But if you report another burn code, such as 16015 (... under anesthesia, medium or large, or with major debridement), you will have to append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to E/M code 99202.

Medicare requires physicians to use modifier -25 on all starred procedures regardless of the number of global days. A procedure with no global days still keeps a pre- and postoperative period, which your physician schedules in one day. The only codes the Physician Fee Schedule lists as not falling under the global concept, such as venipuncture (36415*, Collection of venous blood by venipuncture), do not need modifiers when your physician performs the procedure with an E/M service.

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