Internal Medicine Coding Alert

Tired of Payers Denying Your Burn Treatment Claims? We Can Help

Experts show you how to improve reimbursement with 16000

When internists serve as primary-care providers, they treat a number of minor burn injuries. And if you rely on E/M codes rather than codes in the 16000 range to report these procedures, you could be costing your practice deserved reimbursement.

Experts answer three common questions that should make coding your internist's burn treatments a breeze.

Q: Which Burn Codes Apply to Internal Medicine Practices?

To select the appropriate CPT burn treatment and dressing codes, you should know the burn's size, severity, and whether the patient required anesthesia, coding experts say.

Most of the burn codes (16000-16036) may affect internal medicine practices, but generally, internists treat patients with first- and second-degree burns, says **Ron L. Nelson, PA-C**, president and CEO of Health Services Associates Inc. and HAS Consulting Group Inc., in Freemont, Mich.

Indeed, internal medical practices report code 16020 (Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small) to Medicare more than any other burn code, says **Brett Baker**, third-party payment specialist for the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in Washington, D.C.

Suppose a patient presents to your physician with first-degree burns on his hands. Because most internists will not use anesthesia to treat burn victims in the office, the physician will clean the wound and apply the initial dressing. For this service, you would report 16020.

Internists also frequently report the following codes when treating burns:

1. 16000 - Initial treatment, first-degree burn, when no more than local treatment is required
2. 16025 - Dressings and/or debridement, initial or subsequent; without anesthesia, medium (e.g., whole face or whole extremity).

Q: Are We Correct to Report 99213 for First-Degree Burn Care?

Choosing the correct burn code depends on the internist's documentation. But when you assign 99213 (Office or other outpatient visit for the E/M of an established patient ...) instead of 16000 (Initial treatment, first-degree burn, when no more than local treatment is required) for minor burn treatment, you may be costing your practice about $20 a visit.

Suppose an elderly patient presents to your internist with first-degree sunburn on the face and arms. The physician cleans the burns and applies ointment. Because your physician provided initial treatment, you could report 16000. As long as the medical documentation supports billing 16000, you should choose this code over 99213 because the burn code pays more.

For example, if you lived in Pennsylvania, and Medicare's HGSAdministrators (HGSA) covered the patient, you could expect about $73 for 16000, based on the 2004 Medicare Physician Fee Schedule. But if you report 99213 to HGSA, you

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would make about $53, a loss of $20.

And, considering that the physician performed a procedure, not an evaluation, when he or she applied the burn's initial treatment, you would be coding to the greatest specificity by using 16000.

Also, don't try to report an E/M service along with a burn code, unless the office visit is a service unrelated to burn care. Both 16000 and 16020 bundle all other physician services related to burn care, Baker says. For instance, you couldn't report 99213 in addition to 16000, unless the medical documentation supported attaching modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). You would use this modifier to show that the office visit didn't relate to the burn treatment.

Q: Do E/M Codes Ever Pay More Than 16000-16020?

Yes, sometimes E/M codes offer higher reimburse-ment rates than burn codes. That's because the amount of payment depends on the time the physician spent evaluating a patient and the office visit's complexity, Nelson says.

Using the HGSA patient example, if the internist spent 25 minutes evaluating the Medicare patient and performed a detailed history, detailed examination and medical decision-making of moderate complexity, you could report 99214. In that case, HGSA would pay your physician roughly $87, which is $14 more than 16000.

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