Codify
BY AAPC

Internal Medicine Coding Alert

You Be the Coder: Decide Method, Simple or Complex, to Solve This I&D Dilemma

Question: One of our diabetic patients recently competed in a marathon. Several days later, he reported to our practitioner with pain and swelling in his left big toe. Our physician noted an area on the toe that was filled with pus, and after numbing the area with a local anesthetic, he performed an incision on the toe and drained the pus from the area. In the process, he also drained several loculations before irrigating and packing the area. Given that there is no site-specific irrigation and drainage (I&D) code for a toe, and that CPT® does not provide a definition for "simple" or "complex" I&D, what codes should we use to document this procedure?

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Answer: The CPT® integumentary I&D codes (10060-10180) make no distinction for the location of the procedure site, just the type of infection or trauma (e.g. pilonidal cyst, removal of a foreign body), and the drainage method (e.g. incision or puncture aspiration). And, as you rightly point out, CPT® also does not precisely define "simple" or "complex."

So, as your provider drained an abscess with an incision, your choices are either 10060 (Incision and drainage of abscess (eg., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single) or 10061 (...complicated or multiple). And given that the physician drained other nearby areas and packed the wound, the whole procedure rises to the level of "complicated or multiple," making 10061 the most appropriate choice.

For this scenario, you would also likely report an evaluation and management (E/M) visit such as 99213 (Office or other outpatient visitfor the evaluation and management of an established patient ...), appending modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service) to indicate that the E/M service and the I&D procedure were separate and distinct services. If you do report an E/M in addition to the I&D, the documentation should clearly substantiate that the work of the E/M was significant and separately identifiable from that of the I&D.

This scenario also calls for an array of ICD-10-CM codes to document the patient's condition. The injury itself can be coded in a number of different ways depending on the way the wound was infected. The most likely choice would be L02.612 (Cutaneous abscess of left foot), though if the infection in the toe was bacterial in nature, L03.032 (Cellulitis of left toe) may also be appropriate.

And you cannot rule out L03.042 (Acute lymphangitis of left toe), especially as the patient has already been diagnosed with diabetes, which you will also need to code with an appropriate diagnosis such as E11.628 (Type 2 diabetes mellitus with other skin complications) or a similar, related code depending on the patient's circumstances (e.g. type of diabetes, nature of complication).

Finally, as the injury was sustained while running in a race, you can add external cause code Y93.02 (Activity, running) to the sequence for a complete diagnostic picture to support the procedures your practitioner performed.