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Internal Medicine Coding Alert

You Be the Coder: Don't Get Bit by Incorrect Stinger Removal Coding

Question: An established patient presented to our internist after being stung by a bee. Our clinician examined the patient and observed that the bee's stinger was present in the patient's right upper arm. He used a pair of tweezers and removed the stinger from the wound. Should I report a foreign body removal code for the scenario? Also, let me know what diagnosis codes I should report for this situation.

Connecticut Subscriber

Answer: In your above-mentioned scenario, your clinician only used a pair of tweezers to grasp the stinger and remove it from the patient's upper arm. Since your clinician did not have to make an incision to remove the stinger, you cannot report it with a foreign body removal code.

If your clinician had made an incision to reach the foreign body and removed it, you could have considered using a foreign body removal code such as 10120 (Incision and removal of foreign body, subcutaneous tissues; simple) or a more site specific code such as 24200 (Removal of foreign body, upper arm or elbow area subcutaneous).

As no incision was made, you should report the service as included in the most appropriate E/M level code (such as 99212-99213, Office or other outpatient visit for the evaluation and management of an established patient ...) that you will report for the visit.

For the diagnosis codes, you will have to report S40.851A (Superficial foreign body of right upper arm, initial encounter) and also report W57.xxxA (Bitten or stung by nonvenomous insect and other nonvenomous arthropods, initial encounter).

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