Internal Medicine Coding Alert

You Be the Coder: Follow-Up Visits and New Problems

Question: An established Medicare patient reports to the internist for a check-up to gauge her reaction to medication for her type II diabetes mellitus. During her visit with one of our non-physician practitioners, the patient removes a bandage on her left forearm and reveals a scabby, oozing laceration. The NPP cleans the wound and then closes it with butterfly strips. Can I report the wound closure separately for this encounter?

Idaho Subscriber

Answer: No, you should not report the wound closure; roll the work into the overall E/M level and then select a code. So if the notes for the check-up and wound closure reflect a level-three service, report the following:

• 99213 (Office or other outpatient service for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; medical decision making of low complexity) for the E/M

• 250.00 (Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled) appended to 99213 to represent the patient's diabetes

• 881.00 (Open wound of elbow, forearm and wrist; without mention of complication, forearm) appended to 99213 to represent the patient's wound.

Remember: To fit CPT's wound closure definition, the provider must utilize "sutures, staples, or tissue adhesives, either single or in combination with each other, or in combination with adhesive strips." Since the NPP only used adhesive strips, you'll need to represent the work with an E/M code.

Also: Do not report this visit incident-to the internist. You must report this visit under the NPP's National Provider Identifier (NPI), because the NPP treated a new problem (laceration) in addition to the patient's diabetes. To code incident-to the physician, the NPP must follow the internist's care plan for the entire encounter.