Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Does Your Shoulder Incision And Drainage Coding Make the Grade?

Hint: Get to the right code by confirming what your surgeon drained.

Your surgeon may perform incision and drainage procedures in the shoulder area to treat an abscess, hematoma, infected bursa, or bone abscess. You'll stand a much better chance of hitting the right codes for these services if you can identify what your surgeon actually drained.

Key: Your surgeon's approach may be similar, but the tissues incised and the depth of dissection to reach the pus or blood determines how you can report the drainage.

Turn To Single Code for Blood or Pus

Shoulder abscesses are a common postoperative complication. In this case, your surgeon may not make a new incision but may rather prefer to drain the abscess through the existing incision.

For example, you may read that around three weeks after a shoulder surgery, your surgeon returned the patient to the operating theater to drain an abscess. You will report this as a postoperative infection with ICD-9 code 998.59 (Other postoperative infection) and for the abscess drainage, you report code 23030 (Incision and drainage, shoulder area; deep abscess or hematoma).

You will also append modifier 78 (Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period) as this wasn't a planned return to the procedure room. "Your surgeon will carry the incision down through the deep subcutaneous tissues and deeper still in the fascia or muscle to reach the abscess or hematoma," says **Josie Dunn, CPC**, Department of Orthopedics, University of Maryland Faculty Practices, Maryland. "Code 23030 is used when an incision is made; any accumulated fluid is allowed to drain, manual compression is often applied to assist with the drainage, and this generally is followed by an irrigation of the wound with antibiotic solution," says **Ruby O'Brochta-Woodward, BSN, CPC, CCS-P, COSC, ACS-OR,** compliance and research specialist, Twin Cities Orthopedics, P.A.

Note: You report code 23030 irrespective of whether your surgeon is draining an abscess or hematoma in the shoulder area. The same code applies to both. "This code can be used if either an abscess or hematoma is being drained," says Woodward.

Make Sure You Exclude Debridement

You need to confirm whether your surgeon provided any debridement. Code 23030 is not ideal when your surgeon does a debridement in addition to the drainage. You may read through the operative note to ascertain if any necrotic tissue was removed. "If there is documentation of necrotic tissue being removed, either using sharp instrumentation such as scissors, scalpels or rongeurs, or use of a pulsevac or high pressure water jet, then this can be considered a debridement and not simply an irrigation and drainage," says Woodward.

Coding: When your surgeon documents debridement, you will turn to codes 11042 (Debridement, subcutaneous tissue [includes epidermis and dermis, if performed]; first 20 sq cm or less) -- +11047 (Debridement, bone [includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed]; each additional 20 sq cm, or part thereof [List separately in addition to code for primary procedure]). The choice of code will depend upon the depth of debridement and the size of the wound your surgeon documents.

Tip: "Watch for wording such as subfascial or subcutaneous or the mention of specific muscles such as the deltoid/triceps/biceps. Watch for documentation of debridement of bone and why the bone is being debrided. This series of codes also requires documentation of size of the wound," says Woodward.

Confirm The Structure Incised

When you report an incision procedure for drainage in shoulder area, you will report code 23031 (Incision and drainage, shoulder area; infected bursa) or 23035 (Incision, bone cortex [e.g., osteomyelitis or bone abscess], shoulder area) for drainage of infected bursa or bone, respectively. "Coding for drainage of infected bone is different from drainage of deep abscess in shoulder as the physician does not excise bone in 23030 or 23031," says Dunn. "The bursa is sandwiched between the rotator cuff muscles and the outer layer of large bulky muscles. It is a fluid containing sac between two moving structures that helps to reduce friction."

Make sure your surgeon documents the drainage of the bursa. "Documentation would state an incision is made into the bursa, and purulent material, cloudy fluid, or bloody fluid was drained. You may further read that the bursa was irrigated with of antibiotic solution and a drain may be placed before the wound is closed," says Woodward.

Example: You may read that for a patient who complained of shoulder pain and limitation of mobility, your surgeon obtained an X-ray which revealed a significant periosteal reaction and an irregularity at the proximal metaphysis of the humerus. You may further read that your surgeon used a deltopectoral approach to expose the shoulder joint and proximal humerus and then debrided the lytic area in the metaphyseal region of the humerus and provided saline irrigation. Before terminating the procedure, your surgeon will then obtain an intracapsular biopsy. This biopsy will not reveal any malignancy. The biopsy report may confirm the presence of synovial tissue with acute and chronic inflammation and micro abscess formation.

In this case, you confirm that your surgeon is clearing the necrotic bone and granulation tissue in a patient who had an osteomyelitic focus. You report this with code 23035. "If the infection is in a contained area of bone where the provider is simply making an incision, draining the abscess, curetting out the surrounding bone and soft tissue, irrigating and closing, you will be coding 23035," says Woodward. "This tends to be done for acute osteomyelitis. Antibiotic beads may be inserted. Drains are often placed."

In a patient with osteomyelitis, you may also report the antibiotic beads if your surgeon inserts any. "Remember to report 11981 (Insertion, non-biodegradable drug delivery implant) if your surgeon places antibiotic beads that will later be removed," says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P**, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA.

Your choice of codes will differ entirely if your surgeon makes an incision into the joint(s). "If either scenario resulted in an arthrotomy or incision into the joint, then we would be looking at either 23040 (Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body) or 23044 (Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body) depending upon the joint invaded," says Woodward.