Part B Insider (Multispecialty) Coding Alert

Reader Question: Know When Aspiration Becomes Drainage

Question: A patient presented to the ED with a peritonsillar abscess (PTA) and underwent a needle aspiration to confirm the presence of pus in the tissues. During this procedure, the physician determined that the abscess could be drained completely with the needle aspiration. He subsequently used an 18-gauge spinal needle and aspirated the pus with a 10-cc syringe. When attempting to bill for this, I noticed that the only codes addressing a PTA involve "incision and drainage." What code is best used to bill an aspiration without an incision?

Answer: If no incision was made, you might consider code 10021 (Fine needle aspiration; without imaging guidance) or code 10160 (Puncture aspiration of abscess, hematoma, bulla, or cyst), for an aspiration procedure to confirm the presence of pus in the tissues only.

However, most ED groups would consider the second needle insertion to be making the incision needed to report the I&D code. Given that understanding, the most appropriate code would be 42700 (Incision and drainage abscess; peritonsillar) if draining the abscess was the primary procedure. CPT® does not require that the incision must be made with a scalpel for that procedure.