Outpatient Facility Coding Alert

Coding: Clear Up Your I&D Coding Confusion With These 2 Coding Scenarios

Know the specifics of superficial vs. complicated I&D.

How confident are you when it comes to appropriate coding for your incision and drainage (I&D) claims? Don't fret digging deep into the nitty gritties of documentation. Here is a quick rundown on how to differentiate between different I&Ds for a patient, and avoid miscoding a claim.

What All Goes Into A "Superficial" I&D?

"A simple I&D includes drainage of the pus or purulence from the cyst or abscess," says **Sarah Goodman, MBA, CHCAF, CPC-H, CCP, FCS**, president of the consulting firm SLG, Inc., in Raleigh, N.C. "The physician leaves the incision open to drain on its own, allowing for healing with normal wound care." If the dermatologist performs simple/single I&D, you'd report it with 10060 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single).

"A simple or single abscess is limited to a small collection of purulent material, such as a paronychia, a small cyst, or the type of pus collection generally found around an infected hair follicle," adds **Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC**, CEO of Edelberg + Associates in Baton Rouge, La. Here is a coding example from Edelberg:

Scenario 1: A 12-year-old established patient complains of a painful, red, and swollen area around the nail margin on his left ring finger, form which he can express a small amount of pus. The provider performs an expanded problem focused history, detailed examination and moderate medical decision making.

The provider administers a digital block with 1 percent lidocaine and, performs a simple I&D of the abscess of the nail. She also obtains a wound culture for further investigation. The provider cleans and bandages the area, instructs the patient on wound hygiene, and asks the patient for a follow up visit in a week if the condition does not improve.

Here is a list of services and codes you must remember to code:

- For a simple I&D procedure, report 10060.
- If the provider's office is to perform a complete culture, you may report 87040 (Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates [includes anaerobic culture, if appropriate]). However, if the provider is merely collecting a sample to send to an outside lab for further investigation, then you may not report this. You may not code for collecting the culture sample.
- For the evaluation and management (E/M) service, report 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity...).
- Append 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 99214 to imply that the E/M service was a separate service.
- Code L03.022 (Acute lymphangitis of left finger) to represent the patient's abscess.
- Another ICD-10 code option could be L02.512 (Cutaneous abscess of left hand) as the chart doesn't indicate lymph node involvement, Goodman says.

Simplify Your Coding Options For 'Complicated' I&D

"A complex I&D includes placement of a drainage tube to allow for continuous drainage or packing to facilitate healing,"

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Goodman says. "In certain cases, tissue excision, primary closure, and/or Z-plasty may be required." If your provider performs complicated/multiple I&D, you'd report it with 10061 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; complicated or multiple).

"The more complicated abscesses are larger and may require probing to break up loculations; they also generally require packing," explains Edelberg. In fact, the provider may use sonography to understand the lesion's extent, especially if there is a suspicion of MRSA (Methicillin-resistant Staphylococcus) infection. Let's understand this better with a coding example from Edelberg:

Scenario 2: A 54-year-old established patient complains of a painful, red, and swollen "boil" on her left buttock. The provider takes a detailed history, performs a detailed physical examination and a moderate MDM. The provider numbs the area using lidocaine, breaks up the loculations within the cyst cavity, drains the pus, and packs the lesion. The provider obtains the wound drainage material and sends to the lab for culture test for MRSA. He advises the patient on wound care and hygiene and asks for a follow-up visit in two days.

On the lines of the previous scenario, you would report:

- CPT® code 10061 for a complicated I&D procedure.
- CPT® code 87081 (Culture, presumptive, pathogenic organisms, screening only) for the culture, only if your office is performing the complete culture.
- CPT® code 99214 for the E/M service.
- Modifier 25 appended to 99214 to show that the E/M was a separate, significantly identifiable service.
- The ICD-10-CM diagnosis of L03.317 (Cellulitis of buttock). Another diagnosis option in this case could also be: L02.32 (Furuncle of buttock), Goodman says.

The road ahead: Read through the records to identify the exact procedure levels, exact diagnoses and get the reimbursement you actually deserve, and save your practice from either underpayment or overpayment for services rendered.

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