Codify
BY AAPC

Modifier Coding Alert

Reader Questions: Mind Modifiers When Coding I&D Repeats

Question: A new patient recently reported to our practice complaining of a cyst that was leaking pus in his lower right ribcage. After a level-three E/M service, the physician performed a simple incision and drainage (I&D) on the patient's wound and sent him home. Seven days later, the patient returned complaining of swelling and pain at the I&D site. After a level-two E/M service, the physician determined that the same area was infected again. He repeated the simple I&D procedure, and sent the patient home. How should I code these encounters?

Tennessee Subscriber

Answer: Since this question involves a pair of encounters, we'll tackle the coding questions one encounter at a time:

Encounter 1: For the initial I&D, report 10060 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single). Also, report 99203 if the patient is new to the practice and the documentation supports the level (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity) with 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) appended to show that the E/M and I&D were separate services.

The CPT® code 10060 has a 10-day global period. Since your second encounter occurred during the global, you'll need to check with your payer to see if the infection is part of the routine follow-up care. If so, the second visit would not be billable. If the insurer doesn't consider the procedure part of routine follow-up care, you should be able to report it separately.

Encounter 2: For the second encounter, you should report 99212, with the appropriate documentation (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 problem focused history; a problem focused examination; straightforward medical decision making) for the E/M with modifier 25 appended. Also, report 10060 for the I&D with modifier 76 (Repeat procedure or service by same physician or other qualified health care professional) appended to show that the physician had to repeat the procedure due to unusual circumstances.

Caveat: Coding for repeat I&Ds within the 10-day global period is rare. Your payer may require you to send additional documentation with the claim (or the appeal) explaining why a repeat I&D was necessary seven days later.