CODING Q&A

Coding for I&D, DTaP, and Procedures Included in the E/M Code

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Q. An urgent care that I do billing for has presented a question I would like your input on. A sales rep has stated that urgent care centers are now administering the DTaP vaccine (CPT 90715). Is it appropriate to administer DTaP in urgent care, and, if so, what is the difference between the reimbursement of the Td (90714) and the DTaP (90715)?

– Lynn Gray, Eastern Hills Medical Billing, Cincinnati, OH

A. Patients may use urgent care centers when they have difficulty getting timely appointments for an immunization with a primary care physician. In general, place of service should not change whether it is appropriate or not to administer the vaccine. Any payor, however, may choose to deny a code, based on a contract with the provider or individual payor policies.

When it comes to actual reimbursement, fee schedules are set by payors, so you will need to check with each payor to determine the fee schedule rate for each code. Of course, the code that you use should not be based on reimbursement levels; rather, the code should correlate with the specific service that has been provided. ■

Q. What is the best code to use when we do not repair a laceration and are just cleaning a scrape or contusion?

– Misha Doctor, Nason Medical Center, Charleston, SC

A. CPT and CMS consider cleansing a wound to be a minor procedure that is not separately reported with a CPT or HCPCS code. It is included in the E/M service, and performing this service does not alter the algorithm for calculating the E/M code. ■

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Q. When one of our providers places an ear wick, they write in the code 69399. I've looked in the 2009 CPT code book, and this code is listed under reconstruction auditory canal and is an unlisted procedure, external ear. Do you know if there is another code that we should use for an ear wick?

– Adam Walker, Physicians Care, Chattanooga, TN

A. Again, CPT and CMS consider insertion and/or removal of an ear wick(s) as a minor procedure that is not separately reported with a CPT or HCPCS code. Ear wick insertion is included in the E/M service, and performing this service does not alter the algorithm for calculating the E/M code. ■

Q. How do we code for multiple visits for repeat procedures—for example, when a patient makes several daily clinic visits for removal of packing and repacking of the abscess after an incision and drainage (I&D) of the abscess?

– Scott Cooney, Bellevue Urgent Care, Greater Omaha Area, NE

A. Every procedure code has an associated global period. This global period includes much of the follow-up care during that global period. Examples of procedures and their associated global periods include:

- 96372: IM injection, 0-day global period
- 12001: Simple laceration repair, 10-day global period
- 26720: Fracture finger (when definitive care is performed), 90-day global period

In the case that you describe, wound packing and repacking during the global period for the I&D would be included in the global package. Of course, in some cases the patient does require multiple visits during the global period. Each of these visits would be coded with code 99058, which has no associated reimbursement.

In the case of fractures, however, some follow-up care (i.e., x-rays, cast supplies, and cast reapplications and modifications) is not included in the global care. This even applies to the

global period for definitive fracture care. You may code for these services and supplies in addition to the procedure code for fracture care. ■

Q. What procedure code would I use on incision and drainage of a large (8 cm) skin abscess near the medial right periscapular border? It required probably three times more supplies and time than a usual skin abscess. It was, however, superficial to all muscles. The 20000 code wouldn't seem to reimburse enough.

– Alan L. Carpenter, DO, Upper Valley Urgent Care Center, El Paso, TX

A. There is one code specific to the body area that might apply here: 21501 – Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax.

With several other codes for "deep incision and drainage," CPT is specific in defining "deep" as "subfascial." With this code, however, CPT and CPT Assistant are silent on the definition of "deep." Thus, you should use your clinical judgment to determine whether the abscess would fit the definition of "deep."

There are two general codes for I&D of an abscess:

- 10060 – Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
- 10061 – Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
- The second code, 10061, is probably the best code to use for the procedure you describe. Make sure that your procedure note makes it clear that this was a complicated procedure.

Note: There are also codes for I&D of abscesses (or hematomas) in some specific situations or of anatomic locations (**Table 1**). Because these codes most accurately describe the procedure performed, you should use these codes when they apply. ■

Table 1. I&D Codes for Specific Anatomic Locations

Code	Description
10040	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
10080	Incision and drainage of pilonidal cyst; simple
10081	Incision and drainage of pilonidal cyst; complicated
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
22010	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic
22015	Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral
23930	Incision and drainage, upper arm or elbow area; deep abscess or hematoma
23931	Incision and drainage, upper arm or elbow area; bursa
25028	Incision and drainage, forearm and/or wrist; deep abscess or hematoma
25031	Incision and drainage, forearm and/or wrist; bursa
27301	Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region
27603	Incision and drainage, leg or ankle; deep abscess or hematoma
27604	Incision and drainage, leg or ankle; infected bursa
28001	Incision and drainage, bursa, foot
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas
30000	Drainage abscess or hematoma, nasal, internal approach
30020	Drainage abscess or hematoma, nasal septum
42700	Incision and drainage, abscess; peritonsillar
46050	Incision and drainage, perianal abscess, superficial
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
69000	Drainage external ear, abscess or hematoma; simple
69005	Drainage external ear, abscess or hematoma; complicated
69020	Drainage external auditory canal, abscess

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