CODING Q&A

Coding for Complicated or Multiple I&Ds, Head CT, and Follow-ups—and When to Use CPT 99051

DAVID STERN, MD, CPC

Q. I notice that the code for complicated or multiple incision and drainage (I&D) produces almost twice the reimbursement as the superficial I&D code. When can I code the code 10061 (Incision and drainage of abscess, e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia; complicated or multiple)?

- Anonymous

A. The concept of multiple (i.e., more than one) is straightforward. The concept of *complicated* I&D is less clear. CPC Assistant is quite ambiguous, as it states: "The choice of code is at the physician's discretion, based on the level of difficulty involved in the incision and drainage procedure."

One indication that the code for complicated I&D is appropriate is that the fluid is being drained for tissues deeper than the epidermis, dermis, and subcutaneous tissue. Of course, it is important for the physician to document in the procedure note what deeper tissues are involved. ■

Q. I have a question about CT. If you do a CT of the head using the code 70450, does that code include the reading, or is there another we should bill for the interpretation of the scan?

- Cheryl Kennedy

A. When you bill the code 70450, the code includes the reading of the study. Radiology codes include both the technical component (equipment and personnel involved in performing and preparing the study) and the professional component (physician reading of the study). If you bill the code without a modifier, then you are billing for both the technical and the professional component.

Radiology codes can be split into their separate components by adding modifier -TC to bill only for the technical component and by adding modifier -26 to bill only for the professional component (physician reading of the study). ■

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Q. What is the appropriate code for an 18-month-old established patient that returns for a follow-up on acute suppurative otitis media with rupture of eardrum?

- Marcie, West Bloomfield, MI

A. The concept of the follow-up visit is sometimes confusing. If the patient sees the provider for a routine follow-up visit during the global period for a procedure, then the code 99024 is the appropriate code. In the situation you bring up, however, there is no mention of a procedure, involving a global period, on the initial visit. Thus, assuming that the provider saw the patient for the follow-up visit, the provider should select the E/M code (99212-99215), based on the level performed and documented in the patient's medical record. ■

Q. We are hoping to could get your help answering a coding question. We have a day clinic with operating hours 8:00 a.m. – 1:00 p.m. by appointments only. The facility is considered a freestanding urgent care facility with operation hours of 1:00 pm – 8:00 pm. We know that we have to bill E/M CPT codes for the urgent care, but we are puzzled if we are allowed to use CPT 99051 after 5:00 pm.

- Toni Gonzalez

A. In regards to 99051, this is not an urgent care-specific code. The code may be used by any medical practice that provides regularly scheduled evening, weekend, and holiday hours.

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Many payors may not reimburse for this code. Some payors may reimburse for this code, but only if the payor has the practice you envision enrolled as a true urgent care center.

It is important to note that your practice would not accept walk-in patients during all hours of operation. Thus, this practice does not meet the UCAOA criteria of a true urgent care center. ■

ABSTRACTS IN URGENT CARE

Delaying Appendectomy May Not Be Harmful for Adults with Acute Appendicitis

Key point: Findings validate the practice of treating acute appendicitis urgently rather than emergently.

Citation: Ingraham AM, Cohen ME, Bilimoria KY, et al. Effect of delay to operation on outcomes in adults with acute appendicitis. *Arch Surg*. 2010;145(9):886-892.

The goal of the study was to determine the impact of delay from surgical admission for acute appendicitis to induction of anesthesia on outcomes after appendectomy in adults, using data from 32,782 patients submitted to the American College of Surgeons National Surgical Quality Improvement Program.

The principal exposure was time to operation, and primary study endpoints were 30-day overall morbidity and serious morbidity or mortality.

Appendectomy was performed within six hours of surgical admission in 24,647 patients (75.2%), from more than six through 12 hours in 4934 patients (15.1%), and more than 12 hours after surgical admission in 3,201 patients (9.8%).

Although there were statistically significant differences in operative duration (51, 50, and 55 minutes, respectively; p<.001), these were not clinically meaningful. Similarly, the difference in length of postoperative stay (2.2 days for the >12-hour group versus 1.8 days for the remaining groups; p<.001) was not clinically meaningful.

In regression models, duration from surgical admission to induction of anesthesia did not predict overall morbidity or serious morbidity or mortality. There were no significant differences in adjusted overall morbidity (5.5%, 5.4%, and 6.1%, respectively; p=.33) or serious morbidity or mortality (3%, 3.6%, and 3%, respectively; p=.17).

In an accompanying invited critique, it is noted that these findings validate the practice of treating acute appendicitis urgently rather than emergently. ■

OCCUPATIONAL MEDICINE

sales calls every day. Given five days per week (minus holidays) over a 50-week work year, that is *900* live sales calls a year. How can you fail?! Manage your face time well; cluster your travel, map out the routes to your destinations, and keep meetings brief and to the point.

4. **Emails.** Dedicate an hour at the end of your day (e.g., 4:00 to 5:00 p.m.) to sending an email to virtually everyone you dealt with that day (in order to review and document your interaction). Send confirmation emails concerning your next day's activities, as well.
5. **Clinic tours.** Carefully planned clinic tours for prime prospects should be an integral part of every program's marketing plans. Schedule at least *three* clinic tours each week. That's 150 tours every year, during which prospects can see firsthand what you've been talking to them about on the phone, via email, and in face-to-face meetings.

Discipline is not easy and is not much fun. I am convinced, however, that discipline is the lifeblood of success. If you really want big numbers in 2011, commit to being laser focused on what is best for your sales output each and every hour of each and every day. You may be surprised at how it all adds up. ■

A Disciplined Plan for 2011

Daily	• Complete *10* telephonic sales calls (both introductory and follow-up). • Complete three or four "live" sales calls. • Carve out an email hour including reviews, reminders of the next day's meeting, email responses, and internal briefings. • Fine-tune your time management plan for the following day. • Document your day's activity on your weekly time sheet. • Leave *five* after-hours voicemail messages for clients and/or prospects.
Weekly	• Execute the marketing tactic listed for that week. • Review the previous week's timesheet; compare to year-to-date time allocation; adjust as necessary. • Send out at least *10* introductory letters. • Ensure that you complete at least *three* clinic tours.
Annually	• Develop the following year's marketing plan by November.