
CODING Q&A

# Plantar Warts, Digital Nerve Block in Lacerations, and Established Patients

DAVID E. STERN, MD, CPC

**Q. We had a patient present with 12 plantar warts. The provider used liquid nitrogen to freeze all 12 of the warts. What code should I bill for this procedure?**

A. In this case, you would bill *Current Procedural Terminology* (CPT) code **17110**, "Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions." Use only code **17110** once because the code represents 1 to 14 lesions.

In a case in which more than 14 lesions are removed, you would bill CPT codes **17110** and **17111**, "Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions." CPT code **17110** would be billed for the first 14 lesions, and CPT code **17111** would be billed to include any additional wart ablations.

**Q. We used a digital block instead of a topical anesthetic when we performed a laceration repair. Can this nerve block be billed separately, or is it part of the repair? Also, because this was a simple repair and there is no global period, can we bill for the removal of sutures when the patient needs them removed?**

A. A digital block is part of the laceration repair, as part of the surgical package. CPT guidelines define standards for preoperative and postoperative services that are included in the surgical package as follows:

- Evaluation and management (E/M) service(s) subsequent to the decision for surgery on the day before and/or the day of surgery (including the medical history and physical examination)
- Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia
- Immediate postoperative care, including dictating surgery notes and talking with the family and other physicians or other qualified health-care professionals
- Writing orders
- Evaluating the patient in the postanesthesia recovery area
- Typical postoperative follow-up care for the full length of the applicable global period

The guidelines of the Centers for Medicare & Medicaid Services (CMS) go a bit further than CPT guidelines to include the following postoperative services in their surgical package:

- All additional medical or surgical services required of the practitioner to deal with complications that do not require more trips to the operating room
- Follow-up visits that are related to recovery from the surgery
- Postoperative pain management
- Supplies, except for those identified as exclusions
- Miscellaneous services, such as dressing changes; local incision care; removal of a surgery pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and changes and removal of tracheostomy tubes

You can find more information about the CMS surgical package guidelines at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf.

**David E. Stern, MD, CPC,** is a certified professional coder and is board-certified in internal medicine. He was a director on the founding board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), NMN Consultants (www.urgentcareconsultants.com), and PV Billing (www.practicevelocity.com/urgent-care-billing/), providers of software, billing, and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

*"There are often good reasons to ask extensive medical history questions and perform a comprehensive physical examination."*

CMS did remove the 10-day global period for simple wound repair codes (CPT codes **12001** through **12018**) in 2011. However, note that the CMS surgical package described here specifically states that the removal of cutaneous sutures and staples is included in the surgical package. For those payors following CPT guidelines for the surgical package, suture removal may be considered part of typical postoperative follow-up care. Check with your payor contracts for specific rules. ■

**Q. I understand that when calculating the E/M level for an established patient, you need to meet only the highest level of two out of the three components (medical history, physical examination, and medical decision-making [MDM]) to determine the level to bill. Should I always count MDM as one of the components?**

A. No specific written criterion states that you must use the MDM as one of the components. However, CMS guidelines state that the medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. Some interpret that to mean that the MDM must be included when calculating the level of E/M.

In reality, there are often good reasons to ask extensive medical history questions and perform a comprehensive physical examination. For example, an established patient presents with a runny nose, cough, and low-grade fever that she has had for 3 days. She has taken acetaminophen but has not had relief. She is an elementary-school teacher exposed to many children each day. Careful questioning indicates that one of these children recently had meningitis. A detailed history is obtained and a comprehensive examination is performed, and both are documented. The assessment is that the patient has a cold, and she is advised to drink plenty of liquids and to take acetaminophen for any aches. The cold will run its course and should be gone within 3 to 4 days. She is further instructed to stay home from work if she develops a fever. Currently, she is not considered to be contagious. In this example, the MDM is low, but it may still be appropriate to bill a level 4 E/M because a comprehensive history and examination were medically necessary in order to determine the correct diagnosis and treatment options. ■



*Disclaimer: JUCM and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.*