The ABCs of Coding
Pediatric Clinic Procedures

Facilitated by
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Objectives and Agenda

- To network with colleagues
- To understand the coding and required documentation of common ped procedures
- To prevent denials by understanding the appropriate use of modifiers, and the operational steps you can implement at your practice
Disclosure Statement

The information presented and responses to questions posed are not intended to serve as coding or legal advice. Although every reasonable effort has been made to assure the accuracy of the information provided, the ultimate responsibility lies with the attendees to ensure they are coding appropriately. The CPN makes no guarantee that this information is error-free and will bear no responsibility or liability for the results or consequences of the use of this information.

Common Clinic Procedures

- Abscess Drainage
- Cerumen Removal
- Circumcision
- Cord Cauterization
- Foreign Body Removals
- Ingrown Toenail
- Laceration Repairs
- Wart Destruction
- Nail Hematoma
- Supernumerary Digit

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Abscess Drainage

I&D of abscess (eg, carbuncle, suppurative hidradenitis, cutan/subcutan abscess, cyst, furuncle, or paronychia)

10060 simple or single
10061 complicated or multiple

- Use for I&D of sebaceous cyst
- Documentation: location, units, technique
- Post-op period: 10 days
- 2010 RVUs: >10060: 2.81 >10061: 4.77

Cerumen Removal

69210 Removal impacted cerumen (separate procedure), one or both ears

- Use ICD-9 code 380.4
- List only once (inherently bilateral)
- Documentation: impacted cerumen and specific technique used by the provider
- Postop Period: 0 days
- 2010 RVU: 1.30
Cerumen Removal

- Do not report cerumen removal for:
  - Quick removal of small amt to examine the ear
- Cerumen removal may be reported if:
  - Impacted cerumen removal is med neccessary
  - Removal requires significant effort by the provider
- E/M can be billed in addition to 69210 if:
  - There is a signif, sep identifiable E/M documented
  - Different diagnosis is used for the E/M

Example #1

- Pt is seen for an URI. MD clears cerumen to examine ears & performs an EPF history and exam w/low compl MDM
- Coding?
  - 99213 with 465.9 – Code 69210 would not be appropriate in this case because documentation did not show that the cerumen was impacted
Cerumen Removal

Example #2

- Pt is seen for an URI and plugged ears. MD removes impacted cerumen, which involves considerable work. MD performs an EPF H&P w/low compl MDM.

- Coding?
  - 99213-25 with 465.9
  - 69210 with 380.4 – OK to bill because it required the skill of the physician and cerumen was impacted

Circumcisions

54150 Circumcision, using clamp or other device with regional dorsal penile or ring block

- Do not report the regional block separately (eg, 64450)

- Issues with medical necessity
  - Recommend obtaining a waiver
Circumcisions

- Use ICD-9 code V50.2 for a routine circumcision
- Documentation: specifics of the procedure as well as any regional block performed
- Postop Period: 0 days
- 2010 RVU: 4.65

Cord Cauterization

17250 *Chemical cauterization of granulation tissue (proud flesh, sinus, or fistula)*

- For cord cauterization using silver nitrate
- Documentation: specifics of procedure including the cauterization technique
- Postop Period: 0 days
- 2010 RVU: 1.89
Foreign Body Removals

**Ear**

69200 *Removal FB from external auditory canal; without general anesthesia*

- Do not use for removal of vent tubes
- Use ICD-9 code 931 *FB in ear*
- Documentation: specifics of procedure & FB (eg, rock)
- Postop Period: 0 days
- 2010 RVU: 3.12

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**Eye**

65205 *Removal of FB, external eye; conjunctival superficial*

- Use of operating microscope is included
- Use ICD-9: 930.1 *(conjunctival sac)* or 930.8 *(other and combined sites on external eye)*
- Documentation: specifics of procedure and FB
- Postop Period: 0 days
- 2010 RVU: 1.42
Foreign Body Removals

**Nose**

**30300** Removal FB, intranasal; office type proc

- Topical vasoconstrictive agents and local anesthesia is included
- Documentation: specifics of procedure and FB (eg, Lego®)
- Use ICD-9: 932 *Foreign body in nose*
- Postop Period: 10 days
- 2010 RVU: 5.68

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**Ingrown Toenail**

**11765** Wedge excision of skin of nail fold (eg, for ingrown toenail)

- Topical or regional anesthesia is included and not reported separately
- Use ICD-9 code 703.0 *Ingrowing nail*
- Documentation: specifics of the procedure
- Postop Period: 10 days
- 2010 RVU: 3.32
Laceration Repairs

Documentation

- Documentation must show:
  - The body location of the laceration repair
  - Sum of length(s) of wound(s) – in centimeters
  - Type of repair (simple, intermediate, complex)
- You will be unable to code if provider only documents the number of stitches placed

Laceration Repairs

Coding

- Simple laceration repairs (most common) are grouped by body location
  - 12001-12007 Scalp/neck/axilla/ext/genit/trunk/extrem
  - 12011-12018 Face/ears/eyelids/nose/lips/muc membr
- Then broken down by length of wound within the set of codes for body location
- All simple laceration repair codes have a 10 day postop period
### Laceration Repairs

#### 12001-12007

<table>
<thead>
<tr>
<th>Codes</th>
<th>Length of Wound</th>
<th>2010 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>12001</td>
<td>2.5 cm or less</td>
<td>3.85</td>
</tr>
<tr>
<td>12002</td>
<td>2.6 cm to 7.5 cm</td>
<td>4.10</td>
</tr>
<tr>
<td>12004</td>
<td>7.6 cm to 12.5 cm</td>
<td>4.82</td>
</tr>
<tr>
<td>12005</td>
<td>12.6 cm to 20.0 cm</td>
<td>6.00</td>
</tr>
<tr>
<td>12006</td>
<td>20.1 cm to 30.0 cm</td>
<td>7.43</td>
</tr>
<tr>
<td>12007</td>
<td>over 30.0 cm</td>
<td>8.34</td>
</tr>
</tbody>
</table>

#### 12011-12018

<table>
<thead>
<tr>
<th>Codes</th>
<th>Length of Wound</th>
<th>2010 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>12011</td>
<td>2.5 cm or less</td>
<td>4.09</td>
</tr>
<tr>
<td>12013</td>
<td>2.6 cm to 5.0 cm</td>
<td>4.51</td>
</tr>
<tr>
<td>12014</td>
<td>5.1 cm to 7.5 cm</td>
<td>5.29</td>
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<tr>
<td>12015</td>
<td>7.6 cm to 12.5 cm</td>
<td>6.65</td>
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<td>12016</td>
<td>12.6 cm to 20.0 cm</td>
<td>7.92</td>
</tr>
<tr>
<td>12017</td>
<td>20.1 cm to 30.0 cm</td>
<td>6.94</td>
</tr>
<tr>
<td>12018</td>
<td>over 30.0 cm</td>
<td>8.39</td>
</tr>
</tbody>
</table>
Laceration Repairs

Coding Guidelines

- If removing a lesion that requires intermediate repair, the repair can be billed in addition to the skin lesion removal code.
- Laceration repair codes include:
  - Sutures
  - Staples
  - Tissue Adhesives (e.g., dermabond)

- When repairing multiple wounds, add the lengths of those wounds in the classification (type of repair and body location) and report only 1 code.
- If only using adhesive strips to repair, the laceration repair codes should not be used – report an E/M code for this service.
Laceration Repairs

Example #1

- Provider uses dermabond to repair a 1.5 cm laceration on the child’s forearm
- Coding?
  - 12001 w/881.00 – Repair codes can be used when utilizing sutures, staples or tissue adhesives (eg, dermabond)

Example #2

- Provider sutures 2 lacerations: 1st is 2.0 cm on the left forearm, 2nd is 1.5 cm on the right thigh
- Coding?
  - 12002 w/884.00 and 890.0
  - Add up the sum of the lengths of the repairs (per code family) and submit 1 code
Destruction of Warts

Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), of benign lesions other than skin tags or cutaneous vascular proliferative lesions:

- **17110** up to 14 lesions
- **17111** 15 or more lesions

- Report with only 1 unit
- Use 17110 or 17111 based on # of lesions

Use ICD-9 codes 078.12 for plantar warts or 078.19 for common or flat warts or 078.0 for molluscum contagiosum

- Documentation: technique used, body location and the # of lesions
- Postop Period: 10 days (for both codes)
- 2010 RVU:
  - > **17110** – 2.78
  - > **17111** – 3.32
Nail Hematoma

11740 Evacuation of subungual hematoma

- Electrocautery needle pierces nail and pressure is applied to force the blood out
- If done on mult digits, use finger or toe modifiers to show specific locations
- Documentation: specifics of proc & location
- Postop Period: 0 days
- 2010 RVU: 1.15

Supernumerary Digit

11200 Removal of skin tags, mult fibrocutaneous tags, any area; up to and including 15 lesions

- Index in CPT® under supernumerary digit shows code 26587 Reconstruction of polydactylyous digit, soft tissue and bone
- Additional instructions in tabular section: “(For excision of polydactylyous digit, soft tissue only, use 11200)”
Supernumerary Digit

- Use 11200 for removal of supernumerary digit using ligature strangulation
- Usually performed on newborns
- Postop Period: 10 days
- 2010 RVU: 2.14

-25 Modifier

CPT Definition

- Significant, Separately Identifiable E/M by the Same Physician on the Same Day of the Procedure or Other Service
- Requiring additional work
- Documentation: E/M must support level reported
- Beyond the usual preop and postop care
- Different dx not required
-25 Modifier

- This modifier should be appended to CPT® codes for E/M services (eg, 99213)
  - Indicates the E/M is significant & separate from the other procedure (or other service) billed on same day by same provider
  - Allows for separate reimbursement and prevents bundling denials

- Q: Should I report an E/M in addition to the other service performed?
- A: Yes, if the answer is yes to the following:
  - Were key components of the E/M documented?
  - Could the E/M stand alone as a billable service?
  - Is there a different diagnosis for the E/M service?
  --or--
  - If dx is same, was extra work performed above and beyond typical pre- and post-operative work?
-25 Modifier

- E/M may be reported in addition to:
  - Minor surgical procedure: 0-10 day post op (eg, 17110 for common wart destruction)
  - Preventive medicine visit (eg, 99393)
- Documentation: E/M should be clearly discerned from the procedure or other service
  - Ideally, with a separate note (eg, “A significant, separate E/M was performed to evaluate........”)

Modifier -25

- Should E/M be reported w/ Procedure?
- No, it is included and not separately reported if:
  - Pt presents for a scheduled procedure
  - Pt presents for an uncomplicated simple procedure (eg, intranasal FB removal)
Modifier -25

Should E/M be reported w/ Procedure?

Yes, it may be considered significant if:
- After taking the necessary history & exam to determine what is wrong, a procedure is done
- Procedure is done at same visit as well child check

Remember: Most procedures (even minor ones) include an element of pre- and post-op eval

Scenario 1: 7 yr old est pt presents for wart treatment. She was in a few weeks ago and treated, but warts were not completely destructed. Mom wants them re-treated.

Coding?:
- 17110 for up to 14 lesions w/ 078.19
- OK to report because it is outside the global surgical package (10days) for 17110
Modifier -25

Scenario 2: 7 yr old est pt presents for a scheduled WCC. During the course of the WCC, Mom asks to have warts re-treated. She was in a few weeks ago and treated, but warts were not completely destructed.

Coding?:
- 99393-25 w/V20.0 and 17110 w/078.19
- Link diagnosis codes appropriately

Modifier -25

Scenario 3: 2 yr old est pt presents with a 1.5 cm laceration on the forehead. Provider assesses the patient for any head injury (EPF history and exam with mod MDM) and then performs a simple repair of the laceration.

Coding?:
- 99213-25 and 12011 w/ 873.42
- Per CPT®: “Different diagnoses are not required for reporting of the E/M services on the same date”
Other Modifiers

- **-24 Modifier**
  - Use on unrelated E/Ms done during postop period

- **-79 Modifier**
  - Use on unrelated procedure codes done during postop period of another procedure

- **-76 Modifier**
  - Use on a procedure that was repeated
  - If the code's description states “each,” use units rather than use -76 on multiple lines of claim

Finger and Toe Modifiers

- **F1 – FA for specific fingers:**
  - Left: F1 (2\(^{nd}\)), F2 (3\(^{rd}\)), F3 (4\(^{th}\)), F4 (5\(^{th}\)), F5 (thumb)
  - Rt: F6 (2\(^{nd}\)), F7 (3\(^{rd}\)), F8 (4\(^{th}\)), F9 (5\(^{th}\)), FA (thumb)

- **T1 – TA for specific toes**
  - Left: T1 (2\(^{nd}\)), T2 (3\(^{rd}\)), T3 (4\(^{th}\)), T4 (5\(^{th}\)), T5 (great toe)
  - Rt: T6 (2\(^{nd}\)), T7 (3\(^{rd}\)), T8 (4\(^{th}\)), T9 (5\(^{th}\)), TA (gr. toe)
Other Modifiers

**Scenario 2**: 2 yr old est pt presents for a removal of a FB in nose. Patient was seen last week for a wart destruction.

**Coding**: 
- 30300-78 w/932 
- Modifier -79 would be needed to show that an unrelated procedure was performed within the global period of the wart destruction.

Other Modifiers

**Scenario 3**: 12 yr old est pt presents for treatment of subungual hematomas of the 2\textsuperscript{nd} and 3\textsuperscript{rd} fingers of the right hand after smashing fingers last week in a door. Provider evacuated hematomas to relieve pressure in both fingers using an electrocautery needle.

**Coding**: 
- 11740-F6 and 11740-F7 w/ 923.3 
- Use finger modifiers to prevent bundling denials.
Operational Procedures

- **Charge Tickets**
  - Include global days
  - Include modifiers -24, -25, -78 and -79

- **Educate Providers**
  - Appropriate use of modifiers
  - Global surgical package concept

- **Claims Denial Management**
  - Review all bundling denials
    - Go back 90 days in claims history (fracture care)

Questions

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Sources

- CPT® 2011 and CPT® Assistant
  - Published by the American Medical Association
- 2011 Pediatrics Coding Companion
  - Published by Ingenix
- AAP – American Academy of Pediatrics
  - www.AAP.org
- AAFP – American Academy of Family Practice
  - www.AAFP.org