Clinical Practice Guideline: **Abscess Incision and Drainage**

Date of Implementation: **June 18, 2015**

Product: **Specialty**

GUIDELINES

A. American Specialty Health – Specialty (ASH) considers services consisting of **CPT®** Codes 10060, 10061, or 10160 to be medically necessary, for incision and drainage **upon meeting all of the following criteria**:

1. When supported by **1 or more of the following diagnoses**:

ICD-10 Code	ICD-10 Code Description
E08.628	Diabetes mellitus due to underlying condition with other skin complications
E09.628	Drug or chemical induced diabetes mellitus with other skin complications
L02.611 - L02.619, L03.031 - L03.049	Cutaneous abscess of foot, and cellulitis and acute lymphangitis of toe
L03.115 - L03.119, L03.125 - L03.129	Cellulitis and acute lymphangitis of lower limb
L44.8 - L44.9, L45	Papulosquamous disorders
L94.2	Calcinosis cutis
L98.8	Other specified disorders of the skin and subcutaneous tissue
L99	Other disorders of skin and subcutaneous tissue in diseases classified elsewhere

AND

2. Pain (unless patient has neuropathy in area) and inflammation are present.

B. ASH considers services consisting of **CPT®** Code 10140 to be medically necessary, for incision and drainage **upon meeting ALL of the following criteria**:
   1. When supported by **1 or more of the following diagnoses**:

ICD-10 Code	ICD-10 Code Description
G97.31 - G97.32, G97.51 - G97.52	Intraoperative or postprocedural hemorrhage and hematoma of a nervous system organ or structure complicating or following a nervous system procedure
I97.418, I97.42, I97.618, I97.620 – I97.622	Intraoperative or postprocedural hemorrhage and hematoma of a circulatory system organ or structure complicating or following a circulatory system procedure
L76.01 - L76.02, L76.21 - L76.22	Intraoperative or postprocedural hemorrhage and hematoma of skin and subcutaneous tissue complicating or following a dermatologic procedure
M96.810 - M96.811, M96.830 - M96.831	Intraoperative or postprocedural hemorrhage and hematoma of a musculoskeletal structure complicating or following a musculoskeletal system procedure
S80.10XA - S80.12XS	*Contusion of lower leg
S87.80XA - S87.82XS	*Crushing injury of lower leg
S90.111A - S90.229S	Contusion of toe
S90.30XA - S90.32XS	Contusion of foot
S97.00XA - S97.02XS	Crushing injury of ankle
S97.101A - S97.129S	Crushing injury of toe(s)
S97.80XA - S97.82XS	Crushing injury of foot
T88.8XXA - T88.8XXS	Other specified complications of surgical and medical care not elsewhere classified

*Treatment of these diagnoses as allowed by State Podiatry scope of practice law.

AND

   2. Pain (unless patient has neuropathy in area) and inflammation are present.

CPT® Codes and Descriptions

CPT® Code	**CPT® Code** Description
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
10140	Incision and drainage of hematoma, seroma or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst

BACKGROUND

Incision and drainage or puncture aspiration describes the mechanical task of introducing a sharp sterile instrument into a discrete subcutaneous collection of pus, blood, or other fluid for the purpose of removing from the lesion said pus, bacteria, blood, necrotic tissue, or other toxins, to promote resolution of infection, inflammation, and pain or to obtain material for diagnostic analysis. Incision and drainage services are covered for treating abscesses (e.g., carbuncle, cutaneous or subcutaneous abscess, cyst, furuncle, post-operative wound infections, or paronychia). Incision and drainage of hematomas, seromas, cysts, or other pathologic fluid collections are covered when medically necessary due to pain, inflammation, or infection.

Use of incision and drainage of abscess codes (CPT® codes 10060 and 10061) is limited to lesions with documented abscess and/or pus collection. Use of these codes is not appropriate for treatment of blisters, cysts (including sebaceous cyst), or other fluid collections without the documented presence of discrete abscess, pus collection, pain, infection, or inflammation. An abscess is a circumscribed collection of pus of any size in any location, and as such represents an infection. Abscesses usually exhibit one or more of the following clinical findings: redness, warmth, tenderness, fluctuance, edema, lymphangitis. A lesion not exhibiting such signs or symptoms and that does not contain pus or infected purulent fluid is not an abscess but may be some other type of process requiring incision and drainage such as a hematoma, seroma, bulla, or cyst. A simple abscess generally requires only a single puncture or single incision. A complicated abscess with infection and necrosis usually requires more effort to treat. Examples of complicated abscesses are the following: an abscess with 3-4 tracks requiring breaking up of loculated compartments; an abscess requiring undermining of the skin and subcutaneous tissue and extensive laying open of the cavity. In these circumstances, at minimum, locally injected anesthesia is usually required unless patient has neuropathy affecting the area.

Paronychia is an acute or chronic inflammation of the periungual tissues, which may be associated with infection, purulence, and granulation tissue. Acute paronychia is treated by relieving pressure on the soft tissues either by packing or by removing a section of nail plate and packing. This usually allows for sufficient drainage to avoid the need for incision and drainage of the soft tissues. This technique is used in the foot with some modifications including the removal of larger sections of nail plate and correction of pathomechanical foot function. However, this technique does not involve the direct incision and drainage of a discrete soft tissue pus or fluid collection and should not be coded as an incision and drainage service. It should be coded using CPT® code 11730, avulsion of nail plate, partial or complete, simple; single. When incision and drainage is performed for treatment of paronychia or other infectious processes of the foot without avulsion or resection of the toenail, CPT® codes 10060, 10061 or 10160 should be used.

Paronychia, when sufficiently treated with avulsion of the nail only, should be billed with CPT® code 11730 and not as an incision and drainage. Permanent correction of recurring ingrown toenail by nail resection or wedge excision of the nail lip should be billed with CPT® code 11750 or 11765 and not as an incision and drainage.

If there is inflammation adjacent to a nail or ingrown nail and the only service provided is trimming the edge of the nail, the incision and drainage codes should not be used. Trimming the nail to prevent recurrence of paronychia is considered to be routine foot care, which has limited coverage.

Partial or complete avulsion of the toenail is a common treatment for paronychia in association with an ingrown nail. In fact, incision and drainage is not commonly performed for treatment of paronychia in the foot without avulsion of the toenail. This procedure usually effectively drains any associated infection. Therefore, the provider who performs this procedure to address a localized infection should bill the appropriate CPT® code 11730, and not one for an incision and drainage service.

Billing for incision and drainage procedures (CPT® codes 10060, 10061, 10160) for treatment of paronychia of the foot when avulsion or resection of the toenail has been performed to treat the same condition, is not appropriate.

Pus-producing paronychia without ingrown toenail is relatively uncommon on the foot. Providers billing incision and drainage services for this condition must have medical record documentation available to ASH on request. Then only CPT® codes 10060, 10061, 10160 should be used and not combined with CPT® codes 11750 or 11765.

Incision and drainage services are not payable for treatment of blisters unless there is infection with pus and abscess formation.

Providers performing permanent correction of recurring ingrown nail by nail resection (plate, bed, and nail matrix, partial or complete) or by wedge excision of the nail lip, should bill the appropriate codes, 11750 or 11765, and not incision and drainage service codes. Removal of lytic fragments of the nail plate to relieve symptoms of inflammation without infection of the soft tissues is likewise not an incision and drainage procedure. It is a routine foot care procedure.

Podiatrists are limited in scope of practice by State law. Only those ICD-10-CM codes that are appropriate for the scope of practice will be accepted as reimbursable. The patient's medical record must contain documentation that fully supports the medical necessity for the incision and drainage as well as a full description of the procedure performed.

Claims for CPT® codes 10060 or 10061 with diagnosis of furuncle/carbuncle (L02.621 - L02.639) or hidradenitis suppurativa (L73.2) will be subject to review, as these diagnoses are not commonly found in the foot.

Anesthesia administered by or "incident to" the physician performing the incision and drainage service is included in the reimbursement for incision and drainage services and is not separately payable.

Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this guideline. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. The patient's medical record must document the signs/symptoms exhibited by the patient that required the incision and drainage procedure. This information must be available in the patient's record, if requested for review purposes. Additional information such as photographs, operative reports, or progress notes may be required from any provider who demonstrates a pattern of billing repeated incision and drainage services of the same anatomical area. The pre-operative size, location and appearance of any abscess, hematoma or other lesion claimed to have undergone an incision and drainage service must be clearly documented in the medical record. The operative note must include a description of the procedure (e.g., equipment used), and the approximate quantity (e.g., 1 cc, 5 ml) and quality (e.g., serous, serosanguinous, bloody, exudative, frank pus, malodorous) of the material drained from the collection.

Since the majority of hematomas, seromas and cysts do not require incision and drainage or aspiration, and since this procedure can actually increase the risk of infection, providers reporting these services must document the size, location and quantity of blood, material or serosanguinous fluid drained, as well as the medical necessity of the procedure (e.g., severe pain or infection and failure to resolve with conservative measures).

Pus-producing paronychia without ingrown toenail is relatively uncommon on the foot. Providers billing incision and drainage services for this condition must have medical record documentation available to ASH on request. ASH retains the right to require of select providers photographic documentation of lesions prior to and/or after treatment if there are indications of abuse of any of the codes in this guideline.

If a patient requires incision and drainage services repeatedly for treatment of abscess in the same anatomic location, the medical record must clearly reflect the reason(s) for persistent or recurrent infection and what measures are being taken to avoid infections. A single drainage procedure for most abscesses, hematomas or other collections is often curative. It would be unusual for any individual lesion or collection to require more than two such services. Recurrent fluid or abscess collections or repeated need for incision and drainage services may indicate the need for additional medical or surgical measures to provide definitive treatment. Multiple abscesses or fluid collections in the same patient requiring drainage, more than two times per year in the same location is uncommon.

Coding Guidelines

CPT® code 10060 must be billed for a simple abscess requiring a single incision. CPT® code 10061 must be billed when multiple incisions are required, or the abscess is complicated.

When incision and drainage is performed for treatment of paronychia or other infectious processes of the foot without avulsion or resection of the toenail, incision and drainage services CPT® codes 10060, 10061, or 10160 should be used.

Partial or complete avulsion of the toenails is a common treatment for paronychia in association with an ingrown nail. In fact, incision and drainage is not commonly performed for treatment of paronychia in the foot without avulsion of the toenail. This procedure usually effectively drains any associated infection. Therefore, the provider who performs this procedure to address a localized infection should bill the appropriate code, 11730, and not one for an incision and drainage service.

The correct CPT® code for evacuation of subungual hematoma is 11740 and not any of the incision and drainage CPT® codes from the guideline.

CPT® codes 10060 and 10061 represent incision and drainage of an abscess involving the skin, subcutaneous and/or accessory structures. Therefore, the ICD-10-CM code which supports medical necessity must represent an abscess, not the underlying condition causing the abscess. For example, the ICD-10-CM code for epidermal cyst, sebaceous cyst, steatocystoma multiplex and other follicular cysts of the skin and subcutaneous tissue (L72.0, L72.2 - L72.9) would not meet medical necessity for CPT® codes 10060 or 10061. If the patient had an abscess of a sebaceous cyst, then it would be appropriate to report the

applicable ICD-10-CM code for the abscess (depending upon the anatomical location of the abscess).

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training, and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

References

American College of Foot and Ankle Surgeons (ACFAS) Cosmetic Surgery Position Statement (2020). Retrieved February 12, 2024 from: https://www.acfas.org/policy-advocacy/policy-position-statements/acfas-position-statement-on-cosmetic-surgery

American Medical Association. (current year). Current Procedural Terminology (CPT) Current year (rev. ed.). Chicago: AMA

American Medical Association. (current year). ICD-10-CM. American Medical Association

Centers for Medicare & Medicaid Services. Local Coverage Article: Billing and Coding: Incision and Drainage (I&D) of Abscess of Skin, Subcutaneous and Accessory Structures (A56766). Retrieved on February 13, 2024 from https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=56766&ver=17&LCDId=33563&Date=10%2F05%2F2016&DocID=L33563&bc=AAAAAAAAgAAA&=

Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Incision and Drainage (I & D) of Abscess of Skin, Subcutaneous and Accessory Structures (L33563). Retrieved February 13, 2024 from https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33563&ver=26&Date=10%2f05%2f2016&DocID=L33563&bc=AAAAAAAAgAAA&

Joint Commission International. (2020). Joint Commission International Accreditation Standards for Hospitals (7th ed.): Joint Commission Resources