

Procedures part 2: coding for respiratory services

While some say that the codes for thoracentesis and tube thoracostomy are interchangeable, there are critical differences

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Do you know how to correctly code for the respiratory procedures you perform in the inpatient setting?

In last month's article on coding for procedures, we looked at how to code for inserting a central line. In this month's article, I want to focus on documentation guidelines for three respiratory procedures performed in the inpatient setting.

As you follow patients during the course of their hospital stay, you may find yourself performing procedures that go well beyond a typical evaluation and management service. Depending on the acuity of respiratory distress your patient is encountering, a number of different management options could be necessary.

Here's a look at coding options for three procedures: thoracentesis, tube thoracostomy and emergency endotracheal intubation.

76003 to bill for fluoroscopy, CPT 76360 to bill for CT, or CPT 76942 to bill for ultrasound in conjunction with the above two procedures.

CPT says that CPT 32000 and CPT 32002 are exempt from modifier -51, so you don't have to use a multiple procedures modifier when billing the above services with other procedures.

■ **Tube thoracostomy (CPT 32020).** This code refers to tube thoracostomy with or without water seal for abscess, hemothorax or empyema.

It's important to note that while some coding manuals describe CPT codes 32002 and 32020 as identical, CPT does not view the codes as interchangeable. CPT says that code 32002 should be used for pneumothorax, while code 32020 should be used for abscess, hemothorax or empyema.

As a further example of how the two codes are different, CPT 32020 has been assigned 5.84 relative value units (RVUs), slightly more than the 5.65 RVUs assigned to CPT 32002.

Inpatient respiratory procedure codes for thoracentesis

Procedure	CPT code/modifier	Diagnoses
Subsequent inpatient visit	99233/ modifier -25	Hemorrhagic CVA, pneumothorax, ARDS, rhabdomyolysis, diabetes 2 with peripheral neuropathy, urosepsis
Thoracentesis	32002	Pneumothorax, ARDS
Fluoroscopic guidance	76003	Pneumothorax, ARDS



Three conditions

Where there are similarities between the codes for thoracentesis, tube thoracostomy and emergency endotracheal intubation, each has differences that are critical to proper coding and documentation.

■ **Thoracentesis (CPT 32000 and 32002).** CPT gives us two codes for thoracentesis.

CPT 32000 refers to thoracentesis, puncture of pleural cavity for aspiration, either as an initial or subsequent episode. CPT 32002 refers to thoracentesis with insertion of tube with or without water seal for pneumothorax.

If you need imaging services during either of these procedures, refer to the radiology section of CPT. You can use CPT

Like its cousin, however, 32020 is exempt from modifier -51. As a result, you do not need to use modifier -51 to indicate you're billing for multiple procedures when using this code with other procedures.

If imaging is required during a tube thoracostomy, refer to the radiology section of CPT. You can use CPT 75989 to bill for radiological guidance (fluoroscopy, ultrasound or CT), for percutaneous drainage, or for placement of a catheter.

■ **Endotracheal intubation, emergency (CPT 31500).** Medicare cautions physicians to use this code in emergency or crisis situations, not for elective intubation. Your documentation should support an emergent need through appropriate ICD-9 codes. You may also want to submit a procedure note to support the emergent nature of the procedure.

When coding for respiratory procedures, certain modifiers indicate these services are distinct from other diagnoses.

Like the other codes in this article, CPT 31500 is exempt from modifier -51, so you don't need to use a "multiple procedures" indication when billing it with other procedures.

Critical care codes

While you don't have to use a modifier to indicate that you perform the procedures described in this article on the same day as other services, what happens if you perform these services on the same day as critical care services? Can you bill for respiratory procedures and critical care services on the same day?

The good news is that CPT codes 32000, 32002, 32020 and 31500 are all considered separately billable procedures from critical care services. The catch? You must subtract the time you spend on these three procedures from the time you bill for critical care services.

Modifiers

While you don't have to use modifier -51 for the above codes, you may need to use other modifiers to make sure that your payers process these respiratory procedures when you perform them on the same day as an evaluation and management service.

For example, it would be appropriate to code a subsequent inpatient visit or a critical care service with modifier -25. You want to show that these services are distinct from other diagnoses.

In documenting follow-up care, you must document the appropriate history, exam and medical-decision making within the patient's record. (For more information, see the September 2004 issue of Today's Hospitalist online at www.todayshospitalist.com.) When you perform any type of procedure, you need to document the approach, the findings and the outcome.

Giving coders this information will help them choose between CPT codes that may be very similar. From a reimbursement standpoint, it will help defend possible denials or stall tactics—and put money in your pocket sooner. **TH**

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