Part B Insider (Multispecialty) Coding Alert

Coding Updates: Throw Those Modifiers Away for Multiple Transbronchial Biopsies

CPT 2004 also changes code for fluoroscopic guidance

If your physician is performing multiple transbronchial biopsies, you can stop using the -22 or -59 modifiers to bill for multiple procedures.

The 2004 update to the Current Procedural Terminology includes two new bronchoscopy-related add-on codes: +31632 (Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy[s], each additional lobe [list separately in addition to code for primary procedure]) and +31633 (... with transbronchial needle aspiration biopsy[s] ...).

The two add-on codes should make it easier to receive payment for additional lung and aspiration biopsies without digging for extensive documentation, says **Carol Pohlig**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia. In the past, you might have attached -22 (Unusual procedural services) to biopsy codes 31628 and 31629, and some coders tried to use -59 (Distinct procedural service) when billing the codes twice.

"Often, these attempts were unsuccessful in recovering additional monies," Pohlig says.

Use 31632 along with 31628 for initial transbronchial lung biopsies and 31633 along with 31629 for initial needle aspiration biopsies, says **Laurie Castillo**, president of Professional Coding and Compliance Consulting in Manassas, Va.

The new update revises the descriptor for 31622 to clarify that it, and all indented codes following it, uses fluoroscopic guidance. Also, it's now clearer that 31625 refers to either bronchial or endobronchial biopsies for single or multiple sites. And the descriptor for 31628 clarifies that 31628 applies to a single-lobe biopsy. Finally, 31629's descriptor now specifies a location for needle aspiration biopsy(s): the trachea, main stem, and/or lobar bronchus.

CPT 2004 also includes Category II codes, which help to track performance measurements, in compliance with the Health Insurance Portability and Accountability Act. These codes won't add reimbursement but will make it easier to collect information about quality of care. The use of these codes is optional, and you can't substitute them for Category I codes. They describe E/M service components or test results that are part of the lab test or procedure. The AMA will update the Category II codes semi-annually on its Web site and annually in the CPT book.