

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Bust 4 Myths to Breathe Easy When Submitting Tracheotomy Claims

Beware separate-procedure status of planned tracheostomy.

If you're making assumptions about how to report tracheostomy procedures, you could be costing your practice precious dollars. To ensure this won't happen to you, let our experts guide you through these four steps to master tracheostomy coding.

Myth #1: A Planned Trach is No Different than an Emergency One.

CPT makes a primary distinction between "planned" and "emergency" tracheostomy, and therefore you must determine which of these conditions best describes the procedure when selecting a code. So what's the difference?

"An emergency procedure is just that," says **M. Tray Dunaway, MD, FACS, CSP**, a surgeon, author, speaker and coding educator with Healthcare Value Inc. in Camden, S.C. "Essentially, the patient is immediately imperiled if the physician doesn't perform the procedure." In other words, the patient's airway is so compromised that he is already obstructed or may obstruct at any moment.

Use common sense: Just because the ENT sees a patient and decides to perform a tracheostomy that same day doesn't mean you have an emergency. Rather, an emergency tracheostomy must occur because of an immediate, life-threatening situation.

You should report such emergency procedures using one of two codes:

- 31603 -- Tracheostomy, emergency procedure; transtracheal
- 31605 -- ...cricothyroid membrane.

These two procedures differ according to the location at which the surgeon makes her incision.

Your most likely choice: The incision for transtracheal tracheostomy (31603) occurs in the trachea itself, usually between the second and third rings. This is the more typical procedure that surgeons will use. The surgical cricothyroidotomy (31605) involves an incision in the cricothyroid membrane. Although easier to perform than 31603, 31605 puts the vocal cords at risk of injury and is therefore less common, Dunaway says. "In the emergency department, these trachs are rare."

Myth #2: All Trach Codes Have a Zero-Day Global Period.

If the ENT uses skin flaps to create a more permanent stoma (opening) -- such as for patients with multiple sclerosis, amyotrophic lateral sclerosis (ALS) or other chronic conditions that cause breathing difficulties -- you should turn to 31610 (Tracheostomy, fenestration procedure with skin flaps).

Watch for: Sometimes physicians will use the terms "Bjork flap" or "inferior tracheal flap" to describe skin flaps used in this type of tracheostomy.

Global concerns: Code 31610 is the only tracheostomy procedure to include a 90-day global period. All other trach procedures have a zero-day global period.

Myth #3: Always Report Trach Code, Even if It's An Incidental Procedure.

Because CPT defines all planned tracheostomies as "separate procedures," you must be sure that any trach the ENT provides is not integral to a more extensive procedure. If the trach is incidental (that is, performed as a part of another procedure), you may not report it separately, says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPCR, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J.

Example: If the ENT performs tracheostomy during laryngectomy (31360-31390) or large glossectomies (41140-41145), you may not report the tracheostomy separately. Rather, payment for the trach is included in the fee for the more extensive procedure, of which it is a part.

When you can code: Insurers will allow for a separate, planned tracheostomy when:

- the surgeon performs only the tracheostomy
- the tracheostomy occurs for a different reason than that prompting the primary procedure. In such cases, you should append modifier 59 (Distinct procedural service) to the trach code to distinguish it as a distinct procedure.

Example: An adult patient requires abscess drainage (for instance, 42300, Drainage of abscess; parotid, simple), plus tracheostomy for ventilatory management. In this case, the drainage and trach are distinct and occur for different reasons. Report 42300 for the drainage and 31600 (Tracheostomy, planned [separate procedure]), with modifier 59 appended, for the planned trach.

Myth #5: Patient's Age Doesn't Matter.

If a planned tracheostomy occurs on a patient less than 24 months old, you should report 31601 (... under two years) rather than 31600, Cobuzzi says.

Be aware: The "separate procedure" limitations outlined above apply to 31601 just as they do 31600. Therefore, for children under 2 years old, you should not report 31601 if the tracheostomy is a component of a more extensive procedure.