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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Let Trach Tube Procedure Claims Get You Down

Expert advice on global days and bundling rules to ensure your trach tube claims are spot on.

If your general surgeon changes a tracheotomy tube, should you always charge a 31502 service? And do you know how to pick the right code for tracheostomy procedures?

To answer these and related coding questions, follow our expert tips to help with all your trach claims so you can avoid the pitfalls and seize the opportunities for legitimate pay.

Tip 1: Focus on Tracheostomy Method

If your surgeon places a temporary breathing tube without creating a surgical opening in the trachea, you should code the service as 31500 (Intubation, endotracheal, emergency procedure).

But when your surgeon places an endotracheal tube for long-term breathing help, the surgeon will first perform a tracheostomy to create an external opening in the trachea. To code the procedure, you'll need to use one of the following codes:

- 31600 Tracheostomy, planned (separate procedure)
- 31601 ... younger than 2 years
- 31603 Tracheostomy, emergency procedure; transtracheal
- 31605 ... cricothyroid membrane
- 31610 Tracheostomy, fenestration procedure with skin flaps

Unless your surgeon is acting as an emergency or pediatric physician, you can expect almost all of your tracheostomy cases to be 31600. Reserve 31601 for patients under two years old, and 31603 or 31605 for emergency services (with 31605 representing a riskier procedure that surgeons rarely perform).

Your general surgeon may also sometimes perform a fenestrated tracheostomy procedure, which is a more complicated surgery that results in the patient being able to breathe and speak normally through the mouth while the trach tube is in place.

Separate procedure: When your surgeon performs a planned tracheostomy as part of another surgery, such as a thyroidectomy, you should not claim 31600 in addition to the more comprehensive surgical code, such as 60240 (Thyroidectomy total or complete). But you can report 31600 in addition to a procedure at a different site on the same day, such as an abdominal surgery.

Tip 2: Capture $36 for 31502

What if your surgeon needs to change a tracheotomy tube following a tracheostomy procedure to initially place the tube?

The answer is that you can bill the service as 31502 (Tracheotomy tube change prior to establishment of fistula tract) sometimes.

You should report 31502 only when your surgeon removes the indwelling tube and replaces it fairly soon after the tracheostomy, before the patient has had sufficient healing time to allow a fistula tract to form. Changing the tube when

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the fistula tract is immature is more difficult than changing a tube in a healed tract.

CPT® does not provide specific guidelines on when the fistula tract becomes "established," but it's typically seven to 14 days after the surgery, depending on the patient.

Bottom line: Your surgeon should specifically document the status of the fistula tract in the notes concerning the tube change so that you can correctly code the service. If the patient has a mature fistula tract, you'll need to turn to Tip 3 to learn the proper coding strategy.

Watch global days: If the surgeon replaces the tube as part of normal aftercare during the global period of an initial procedure, you can't separately code the 31502 service. For instance, if the surgeon replaces the tube two days following a 31610 service, which has a 90-day global period, you'll need documentation that the surgeon needed to replace the tube due to a complication in order to separately bill 31502, and then you'll need to append a modifier such as 78 (Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period).

Tip 3: Turn to E/M When 31502 is Out

If your surgeon replaces a trach tube after the formation of the fistula tract, is there any way for you to capture pay for your surgeon's work?

Answer: Yes. When you can't report 31502 for patients who have long-term, established tracheostomies, you can instead report the work with an E/M code sometimes. To capture the work, your surgeon must document the reason he needs to change the trach tube, such as J95.03 **(**Malfunction of tracheostomy stoma).

"There must be some type of complaint that goes along with changing the tube, which is why your doctor is being asked to change it," says **Barbara J. Cobuzzi, MBA, CPC, CENTC, COC, CPC-P, CPC-I, CPCO**, vice president at Stark Coding & Consulting, LLC, in Shrewsbury, N.J. "That is your chief complaint."

You can use that information to help you choose the proper E/M code that reflects the work of changing the tube.

Tip: The surgeon's note should indicate the history portion of the exam with a statement such as either, "Reviewed history of (x date) and remarkable changes include ..."

The surgeon should also document whether the exam is problem focused or expanded problem focused, depending on the medical necessity of the presenting problem.

The last factor in choosing the most appropriate E/M code is medical decision-making, which involves assessing the risk of the procedure given the patient's condition.

Assuming your history is at least detailed or higher and the patient had identified risk factors for the tube change, then you can submit 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity). If the history was below a detailed or if the procedure was a straightforward trach tube change for a patient with no identified risk factors, report the service with 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity).

Watch global days: As with billing for a procedure during the global period, the surgeon needs to demonstrate that the E/M is unrelated to normal follow-up of the global procedure. If that's the case, you'll need to use modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period) when you claim the separate E/ M service.

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