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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: When Can Bronchoscopies and Thoracotomies Be Billed Together? Find Out

See how modifier 59 factors into these billing scenarios.

Most pulmonology coders wouldn't consider billing a bronchoscopy and a thoracotomy together when performed in the same session - after all, the Correct Coding Initiative (CCI) has bundled these codes since 2004.

However, much to the surprise of some coders, there are some instances when you can report these services together by appending modifier 59 (Distinct procedural service) to the bronchoscopy code. You should watch out for cases when 31622 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed [separate procedure]) and 321xx (Thoracotomy, major) could work hand in hand as two separate elements to know when this might be allowable.

Check this example: A scenario which may support reporting both bronchoscopy and thoracotomy is when the physician performs a diagnostic bronchoscopy prior to a thoracotomy and, based upon the results of the bronchoscopy, undertakes thoracic surgery. Keep in mind that this will probably be rarer - in many cases, you cannot bill the codes together.

Use the following case study to determine when reporting these codes together might be the right choice.

Scrutinize the Details

The physician examines a 63-year-old long-term smoker who has hemoptysis and dizziness. A chest X-ray demonstrates a right hilar fullness. A computed tomography image (CT scan) reveals a right hilar mass abutting the superior vena cava and aorta with possible right upper lobe infiltrate associated with multiple lymph nodes. The physician decides to perform a biopsy to remove the mass.

Check Out Biopsy Procedure Note

During the procedure, an anesthesiologist places a double lumen endotracheal tube into the trachea. The physician performs fiberoptic bronchoscopy with a bronchoscope to check the position of the double lumen tube. The nurse anesthetist, under the direction of the anesthesiologist, places a Foley catheter, administers anesthesia, and places a radial artery catheter for postoperative management.

The physician then makes a posterolateral thoracotomy incision and develops subcutaneous flaps. He carefully enters the right pleural space through the sixth intercostal space. He discontinues ventilation from the right lung and then manually palpates the lung.

In the proximal portion of the right upper lobe, the physician palpates a mass. The physician performs a needle biopsy and sends the specimen to pathology. He exposes the hilum and samples multiple lymph nodes in the right paratracheal, subazygos, and posterior hilar areas. All of these specimens go to pathology for frozen sections. All return with the diagnosis of granulomatous inflammation and no malignancy.

The physician then excises the mass. After that, the physician sends all of the tissue separately for cultures. He oversews the incision site with 4-0 Prolene, places chest tubes, reapproximates the ribs, and closes the wound.

The practice reports 32140 (Thoracotomy; with cyst(s) removal, includes pleural procedure when performed) and 31622-59 but the claim for the bronchoscopy (31622-59) is denied. Can you determine what went wrong?

Use Stepwise Approach to Solution

Step 1: Start by referring back to the fiberoptic bronchoscopy mentioned in the report when you work to figure out which codes apply. The procedure may appear on the report loud and clear, but the physician performs a bronchoscopy to determine if the double lumen endotracheal tube is in the correct position, and not to determine surgical resectability. In this case, although necessary for patient safety, you should not code the bronchoscopy procedure.

Step 2: Note that the physician takes the needle biopsies from the right upper lung and sends the biopsies for pathology. He also takes an incisional biopsy. For this procedure, you should bill 32140 or 32151 (Thoracotomy; with removal of intrapulmonary foreign body), depending on the extent of the procedure details and location of the mass.

Why: It includes a major thoracotomy incision with needle biopsy (one or multiple) or incision using a scalpel or scissors.

Step 3: Don't forget to report R59.9 (Enlarged lymph nodes, unspecified) for the diagnosis, says **Carol Pohlig, BSN, RN, CPC, ACS**, senior coding and education specialist at the Hospital of the University of Pennsylvania. Remember reading about the physician removing multiple lymph nodes from the right paratracheal, subazygos areas, and posterior hilar areas? Then you should also include +38746 (Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)) with I88.1.

Tip: Appending modifier 59 in the above scenario does not apply since you should not be reporting a bronchoscopy code in the first place. However, if the patient developed hemoptysis immediately postoperatively and had a bronchoscopy to find the source of the bleeding, you could code 31622 with modifier 59 since the bronchoscopy was separate from the surgical procedure.