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Outpatient Facility Coding Alert

Modifiers: Learn The Ropes of Modifier 53 Coding for Terminated Biopsies

Consider a number of variables, including use of CT guidance.

Biopsy coding can become a relatively simple art if you're coding for a practice that performs these surgeries in high numbers. However, as is the case with most invasive surgeries, you've got to be prepared to code operative notes where the biopsy doesn't go exactly as planned.

Today, you're going to work your way through a few scenarios involving terminated lung biopsies. As you'll see, it takes a strong attention to detail in order to ensure you're coding the claim accurately and precisely.

Give these four examples a try to boost your skills and your confidence on all your future lung biopsy encounters.

Gain Context by Understanding the Why of the Termination

Example: Under computed tomography (CT) guidance a 17-gauge introducer needle was advanced into the right upper lobe near the FDG-avid pulmonary nodule. Immediately after introduction, a pneumothorax was visualized, which I enlarged on subsequent images. No biopsy was obtained, and the introducer needle was removed.

There are a few different kinds of scenarios that will warrant a terminated lung biopsy. Some are initiated by the patient and others the physician. In this encounter, you see that the provider decides to remove the percutaneous needle prior to the biopsy following the discovery of a pneumothorax. Before getting into coding considerations, it might help to understand why a physician will opt to terminate following a discovery such as this.

First, it's important to understand that a pneumothorax that's discovered during a lung biopsy is actually a complication of the procedure itself. This, along with a nicked vessel that causes intrathoracic bleeding, are two of the more common complications to occur during a lung biopsy.

Barry Rosenberg, MD, chief of radiology at United Memorial Medical Center in Batavia, New York, explains why the findings of a pneumothorax warrant an immediate termination of the procedure. "If you discover a pneumothorax, or partial collapse of the lung, during a biopsy, you can be nearly certain that if you continue with the operation the pneumothorax will become larger. That's not a risk any physician is willing to take. Depending on the size of the pneumothorax, the patient may require the immediate insertion of a chest tube, or, at the very least, a few hours of close observation," Rosenberg explains.

As for the coding mechanics of a terminated lung biopsy, you've got to make sure that you code nothing more and nothing less than the services the physician did perform. First, you'll want to address the modifier you'll need to append to one or both services in order to identify that the procedure was not completed. While some coders mistakenly opt for modifier 52 (Reduced Services) in these instances, you should instead be appending modifier 53 (Discontinued Procedure).

Since the lung biopsy was terminated before the nodule was biopsied, you should append modifier 53 to code 32405 (Biopsy, lung or mediastinum, percutaneous needle). Next, you've got to decide whether to append modifier 53 to the code you'll report for CT guidance, 77012 (Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation). It's important to understand that just because the underlying procedure was terminated doesn't mean that all supplementary procedures included in the service were also terminated. "In this example, you should report 77012 without any modifier because the CT guidance was performed to full completion," says **Kimberly M. Fifer, CPC, CEDC**, manager of coding operations at Revenue Cycle

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Management in Roanoke, Virginia.

In addition to being sent electronically, you should send this claim on paper with a written explanation justifying the use of this modifier. This can include a physician's note and the dictation report for the procedure.

Consider Needle Placement When Debating Use of Modifier 53

Example: The patient was prepped and draped in the usual sterile fashion. The entrance site was localized using CT scan guidance and local anesthesia was achieved with 2% lidocaine solution. An 18-gauge coaxial biopsy introducer was inserted into the right lung lesion and the patient demonstrated immediate distress and nausea. The introducer was removed from the patient, blood pressure was taken at 135/91 and O2 sat was 96. Inspiration and expiration chest X-ray demonstrated approximately 25% pneumothorax and patient was transported to the emergency department for care.

This scenario paints a similar picture to that of the previous example. While the procedure itself was terminated due to a distress response from the patient, you can see that the follow-up chest X-ray revealed a pneumothorax.

Based on the fact that the percutaneous needle was introduced and extended to the lesion, you should code this procedure in a similar manner to the last example. Comparatively, the same steps were taken before the procedure was terminated prior to the physician performing a biopsy of the lung. You'll report code 32405 with modifier 53 appended and 77012 without any modifier.

Know When to Avoid Coding 32405 Entirely

Example: Initial scout CT scan was performed to set patient up for lung biopsy; however, with patient prone there is no easy window to access the right lung nodule and biopsy was not attempted.

In this example, you've got a scenario where the physician uses CT imaging to search for an access window to a suspicious lung nodule, but terminates the procedure after determining that access to the nodule was obstructed. You won't be reporting 32405 at all in this instance since the physician did not make an attempt at inserting the needle into the lung nodule.

However, the physician did utilize CT guidance in order to make the final determination that the biopsy was not possible. This means you've got enough documentation to support coding 77012 with modifier 53.

Small Pneumothorax may Be Considered Incidental

Example: An 18-gauge coaxial core biopsy needle was placed at the margin of the lesion and 5 core specimens obtained that were confirmed adequate/positive by Dr. X. The needle was removed, and post-biopsy scan shows a tiny anterior pneumothorax occupying less than 1% of the left hemithorax. The patient was scanned prone and the left lower lobe suspicious nodule was localized from a posterior approach. Successful uncomplicated CT-guided biopsy of suspicious left lower lobe nodule.

You might be wondering what the catch is with this procedure, but there isn't one. This qualifies as a normal lung biopsy and you should code it as such. You'll report 32405 and 77012 without any modifiers outside of your professional component (PC) and technical component (TC) modifiers.

Coder's note: You'll notice this dictation report makes reference to a tiny pneumothorax involving the left hemithorax. If this had been discovered prior to, or during, the biopsy, the physician may have opted to terminate the procedure. However, based on the physician's remarks in the dictation report, the pneumothorax is nothing more than an incidental finding due to its size.

Remember: Modifier 53 does not apply in the hospital or an ambulatory surgery center (ASC) setting. Instead, report modifier 73 (Discontinued Out-patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia) or modifier 74 (Discontinued Out-patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia) depending upon the use and timing of anesthesia.

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