

Anesthesia Coding Alert

Modifier Refresher, 01999: Don't Let 'Discontinued' Derail Your Claims

Follow 3 steps to keep modifier 53 claims on the right track.

Surgeons and anesthesiologists can never know exactly how each step of a procedure will go, which means that some problems and unexpected complications are inevitable. The next time you're coding for a procedure that had to be discontinued, remember our experts' advice on how to handle the situation.

Step 1: Know the Ground Rules for Modifier 53

According to CPT® coding guidelines, you can append modifier 53 (Discontinued procedure) when a physician stops a procedure "due to extenuating circumstances or those that threaten the well-being of the patient." Modifier 53 indicates that an unexpected problem beyond the physician's or patient's control necessitated ending the procedure before it was complete. Pay attention to the additional note in its descriptor, which states that "This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite."

Key point: In situations that merit modifier 53, the procedure isn't stopped because the physician or patient elects to not continue; the physician is forced to do so because of unforeseen circumstances.

"The key thing to remember for modifier 53 is that it is for services that are discontinued for very specific reasons," explains **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-I, CCC, COBGC**, manager of compliance education for University of Washington Physicians. She suggests three details to watch for:

1. The patient develops a contraindication and the procedure must be discontinued for patient health reasons
2. The physician (provider) cannot continue the procedure for some reason (e.g., surgeon cut his hand)
3. The equipment is not working properly and the procedure must be canceled (e.g., laser is not working correctly).

"If one of these reasons does not apply, you should not use modifier 53," she says. "The only exception I'm aware of is that Medicare wants modifier 53 for a patient who is prepped to have a colonoscopy but the prep is inadequate so the patient must be re-prepped and the colonoscopy done at a later time."

Another option: If none of the circumstances Bucknam outlines apply to a discontinued procedure, most payers will instruct you to append modifier 52 (Reduced services) instead of 53.

Step 2: Pay Attention to When the Case Stopped

As an anesthesia coder, your claims revolve around when the anesthesia provider starts and stops his service. When you add a discontinued procedure to the mix, knowing exactly what your provider has done up until that point determines how he'll be paid.

Preoperative care: Your anesthesiologist completes the standard preoperative visit but believes the patient is not a good elective surgical candidate for some reason (for example, because the patient has a fever and lung congestion). He discusses the situation with the surgeon, and the surgeon cancels the case.

If the rescheduled date is far enough in the future to merit another complete pre-op evaluation (usually at least two or three weeks later), you can bill the original exam with the appropriate E/M code. "The pre-anesthesia or preoperative form is usually comprehensive enough to satisfy the E/M requirements," says **Kelly Dennis, MBA, ACS-AN, CAN-PC**,

CHCA, CPC, CPC-I, owner of Perfect Office Solutions in Leesburg, Fl., "but be sure to check the payer's guidelines."

Modifier 53 is not necessary in this scenario.

Before induction: The hospital staff takes Mrs. Smith into the operating room. Before the surgery begins, your anesthesiologist sees an arrhythmia when he begins monitoring her. Her surgeon cancels the case so she can be evaluated and rescheduled.

Check the payer's guidelines before reporting the cancellation to be sure you submit the claim correctly. "I also recommend checking state-specific carrier guidelines, as there are quite a few," Dennis advises. "Using modifier 53 might reduce your payment, so know what to expect."

"If the case is canceled at any point before induction, the documentation requirements for E/M service must be met if you're to bill an E/M code," Bucknam adds.

"Documentation should explain why the case was canceled and when so the coder knows how to bill," Dennis adds. When filing your claim, don't forget the secondary diagnosis codes that help explain the reason for canceled cases:

- Z53.09 - Procedure and treatment not carried out because of other contraindication
- Z53.29 - Procedure and treatment not carried out because of patient's decision for other reasons
- Z53.8 - Procedure and treatment not carried out for other reasons.

After induction: Your anesthesiologist induces Mr. Jones but sees a sudden drop in blood pressure. He advises the surgeon that the case should not proceed. He reverses the anesthesia, and Mr. Jones transfers to the intensive care unit or other area for stabilization and further tests. You have two coding options in this scenario. Some insurers will allow you to report the actual anesthesia code and associated time units based on the planned procedure; others prefer 01999 (Unlisted anesthesia procedure(s)). You should check to see if the specific insurance has a policy indicating how the service should be reported.

"The preferable way is to report the actual anesthesia code since a base value is associated with it," Dennis says.

"Unless the policy requires a 53 modifier for anesthesia, it should not be appended to the claim and, similarly, payment for code 01999 is based on the individual payer's consideration and must be reported if required by the insurer."

Dennis further explains, "Although the surgery may have been canceled, the anesthesiologist has still provided a service. If the case was canceled after induction of a general anesthesia, the anesthesia provider will still need to wake the patient up and make sure she is successfully recovering from the general anesthesia up to the point the patient is transferred to non-anesthesia personnel in the Post Anesthesia Care Unit (PACU). The insurance payment will be reduced by the lesser amount of reported anesthesia time."

Step 3: Submit Adequate Documentation

Just as you should with any claims that include modifiers, if you are required to report modifier 53, ensure you include sufficient documentation to show exactly what anesthesia services were rendered. You may need to appeal if the insurance company allows less than your expected or contracted payment.

Here's why: Submitting modifier 53 alone does not provide the insurance company with enough information to know how to correctly reimburse the provider. Since a discontinued procedure could occur at the early stages of a surgery or after the surgeon performs the majority of work, the insurer will require context behind the discontinuation before reimbursing the provider. Often, the operative report and a note from the office manager will suffice; but the best chance at optimal reimbursement is if the provider is able to contribute a separate note of their own explaining the situation.

Final tip: Keep in mind that although the surgery may have been canceled, if the case is canceled after induction or placement of a regional or monitored anesthesia care (MAC) technique, anesthesia providers will still need to finish their service, Dennis notes.

