Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Don't Let 'Discontinued' Spell Disaster for Your Claims

Learn the best ways to know when modifier 53 applies -- or doesn't.

Your physician went into a procedure expecting things to proceed normally. You expected the same when the file came to you for coding, but now you see that things didn't go as planned.

Do you report the case, or was the extent of your doctor's work covered by preop care? If you file the claim, do you append modifier 53 (Discontinued procedure) or just submit the appropriate surgical or anesthesia code? Read on for some expert guidance on how to handle these scenarios correctly every time.

Know When Modifier 53 Applies

You should report modifier 53 when a physician stops a procedure "due to extenuating circumstances or those that threaten the well-being of the patient," according to CPT. Modifier 53 describes an unexpected problem, beyond the physician's or patient's control, that necessitates ending the procedure. The physician doesn't elect to discontinue the procedure so much as he is forced to do so because of 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 cancelled (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."

Outside the guides: What if the above situations don't apply to your case? Although non-Medicare payerscan make their own rules, Bucknam says most would direct you to append modifier 52 (Reduced services) instead of 53.

Pitfall avoidance: To apply modifier 52 instead of 53, the reduction of services must occur by choice (either the physician's or the patient's) rather than necessity. If your physician determines that the patient requires a service but at a lesser level than the complete code description indicates, or if the patient elects to cancel after the procedure has started but prior to its completion, then modifier 52 is appropriate. You might also turn to modifier 52 when the code specifies a bilateral service but the physician performs the service on only one side.

Check When the Case Stopped

Procedures might stop at any time when the anesthesiologist or surgeon sees some risk that could threaten the patient's health if the case continues. Either physician can cancel the procedure at any one of three points, and your coding will depend on the timeframe.

Preoperative visit: 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. Some carriers suggest you report a consultation code (99241- 99245 for office/outpatient or 99251-99255 for inpatient) when the case is canceled before your physician provides any anesthesia service, according to **Kelly Dennis, MBA, CPC, ACS-AP,** president of Perfect Office Solutions in Leesburg, Fla.

"The pre-anesthesia or preoperative form is usually comprehensive enough to satisfy the E/M requirements," she says. "Other carriers suggest reporting an E/M code, though, so check your carrier's guidelines."

Your doctor's second pre-op visit (when the case actually takes place) is included in the base value of the anesthesia service at the time of surgery. In the past, you might have reported the canceled visit with an E/M code and modifier 53 but that's no longer the case. Current CPT guidelines state that you don't use modifier 53 "to report the elective cancellation of a procedure prior to a patient's anesthesia induction and/or surgical preparation in the operating suite."

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 your carrier 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."

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. Deciding the better coding option might be outlined by the carrier-specific instructions, Dennis says. Some carriers, such as Blue Cross/Blue Shield of Florida, allow you to report the actual code in these situations (based on the planned procedure); others prefer 01999 (Unlisted anesthesia procedure[s]). Either way, you'll also want to append modifier 53.

"The preferable way is to report the actual anesthesia code since a base value is associated with it," Dennis adds. "01999 is individual consideration but must be reported if required by the carrier."

Learn the Difference Between 53 and 73 or 74

Two other modifiers apply to discontinued procedures, but you shouldn't need them to report anesthesia services:

• Modifier 73 -- Discontinued outpatient procedure prior to anesthesia administration

• Modifier 74 -- Discontinued outpatient procedure after anesthesia administration.

"Modifiers 73 and 74 are for the facility coding only," Bucknam explains. "Physicians can't use these modifiers; they would report modifier 53 (when appropriate) whether the service is inpatient or outpatient."

Final key: "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 says.

"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:

• V64.1 -- Surgical or other procedure not carried out because of contraindication

• V64.2 - Surgical or other procedure not carried out because of patient's decision

- V64.3 -- Procedure not carried out for other reasons.