Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Modifier 23 Could Apply--If Your Physician Performed Anesthesia That's 'Unusual'

Knowing enough details about procedure, location can give you the green light.

The time of anesthesiologists only working on cases in the OR are long gone - your providers might be called to help with procedures in any number of places these days. Many of these cases could merit modifier 23 (Unusual anesthesia), so ask yourself three important questions when deciding whether to append 23.

Where Did the Service Take Place?

You can append modifier 23 to many procedures that take place outside the OR if your physician provides sufficient documentation.

Radiology: Radiologists perform an ever-growing range of procedures, many of which require anesthesia because of their invasive nature. However, they might also require anesthesia for MRI procedures, which cross to 01922 (Anesthesia for non-invasive imaging or radiation therapy).

Cath lab: Although technically part of the radiology department, the cath lab staff performs many involvedprocedures that could require anesthesia. Three possibilities include:

- TIPS (transvenous intrahepatic portosystemic shunt) insertion, which crosses to 01931 (Anesthesia for therapeutic interventional radiologic procedures involving the venous/ lymphatic system [not to include access to the central circulation]; intrahepatic or portal circulation [e.g., ransvenous intrahepatic portosystemic shunt[s] {TIPS}])
- Arterial system angioplasty procedures, which cross to 01924 (Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; not otherwise specified)
- Angiography arteriovenous shunt, which crosses to 01916 (Anesthesia for diagnostic arteriography/ venography).

Emergency department: Anesthesia during a cast change or removal is an exception more than the rule, but it could be necessary for small children. Choose the anesthesia code based on the cast site, such as 01490 (Anesthesia for lower leg cast application, removal or repair) or 01680 (Anesthesia for shoulder cast application, removal or repair; not otherwise specified).

Which Special Circumstances Existed?

Many procedures that qualify for modifier 23 don't normally require anesthesia. Documentation of medical necessity - by the anesthesia provider and requesting physician - will help justify modifier 23. Watch for circumstances such as:

Underlying conditions: Parkinson's disease (332.x), mental retardation (317-319), claustrophobia (300.29, Other isolated or specific phobias), and cerebral palsy (434.x, Infantile cerebral palsy; or 437.8, Other and ill-defined cerebrovascular disease; other) are all valid diagnoses for anesthesia during MRIs, line removals, or other seemingly simple procedures.

Patient age: Children are often considered as special circumstances for anesthesia services during non-invasive or invasive radiological procedures and pain management services. Although the procedure may be relatively painless from an adult perspective, a young child may not be able to remain still --" or may have been poked and prodded so many times they must be sedated for the procedure.

What Payer Guidelines Apply?

As in all cases, check your payer guidelines before submitting claims with modifier 23 to ensure you file correctly.

"By definition, the 23 modifier indicates 'a procedure which usually requires no anesthesia or local anesthesia,but because of unusual circumstances must be done under general anesthesia,'" says **Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I,** owner of Perfect Office Solutions in Leesburg, Fla. Translation: The physician or CRNA must administer general anesthesia --" not monitored anesthesia care (MAC) - for the procedure before qualifying for modifier 23.

Example: Aetna requests modifier 23 for "unusual positioning" during a procedure. Check your local payer's policy to ensure you meet the latest requirements. "Check with the payer before submitting the claim to find out about their guidelines," recommends **Catherine Brink, CMM, CPC, CMSCS,** owner of HealthCare Resource Management, Inc., in Spring Lake, N.J. "Of course, documentation of medical necessity is a 'must' and each payer might have designated diagnoses for modifier 23."

Appeals help: Knowing the rules doesn't lead to automatic acceptance, however. Be prepared to appeal any claims with modifier 23 with documentation of medical necessity. Also include a letter of medical necessity from the patient's primary care physician or surgeon to help bolster your position.