Part B Insider (Multispecialty) Coding Alert

RAC Audits: Auditors Home in on Modifiers for Discontinued Procedures

Find out what RACs are reviewing.

Occasionally, you're forced to discontinue a procedure before the patient is even anesthetized. There are a few modifiers that can help you collect some reimbursement for this situation, even if you can't bring in the whole procedure amount. But determining which modifier to use can be a challenge for some practices.

According to the new audit issue posted by Part B RAC Cotiviti on June 28, reviewers are looking at claims for procedures that are discontinued before anesthesia is administered.

In black and white: "Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure where the service is subsequently discontinued," Cotiviti said in the audit details.

"Documentation will be reviewed to determine if the billed procedures meet Medicare coverage criteria and applicable coding guidelines for the use of modifier 73."

Background: RACs are independent contractors that data-mine Medicare claims, review them for errors, and collect contingency fees based on the amounts they recover. Because of how they are paid, RACs' bounty hunter-style payment system encourages them to go after coding and billing errors that are so common and widespread that they will be paid handsomely for discovering (and recovering) overpayments.

Check This Example

Suppose a gastroenterologist begins performing an upper GI (43235, Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)). However, the gastroenterologist has to discontinue the surgery because the patient's health becomes endangered. What is the correct modifier to append in this situation?

The answer will depend on where the service took place, and whose billing you're handling: The gastroenterologist or an ambulatory surgical center (ASC).

Assuming you're billing for the gastroenterologist, the appropriate modifier is 53 (Discontinued procedure), which you would append when the physician begins a procedure or diagnostic test and then decides to terminate it because continuing the procedure threatens the patient's health.

So you would append modifier 53 to the CPT® code of the procedure that was discontinued - which in this case is 43235 - and this applies for the physician fee whether or not sedation was given, says **Glenn D. Littenberg, MD, MACP, FASGE, AGAF**, a gastroenterologist and former CPT® Editorial Panel member in Pasadena, California.

Keep in mind that you won't use modifier 53 if the procedure is cancelled for elective reasons. Instead, you should reserve it for times when the patient's condition warrants halting the service.

If you're billing for an outpatient hospital or ASC, you'll instead use modifier 73 (Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia).

In cases when the service is discontinued after the anesthesia is administered, you'll instead report modifier 74 (Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia).

Always Submit Documentation

Submitting modifier 53 alone does not provide the payer with enough information to know how to correctly reimburse you, so make sure you submit the supporting documentation for appending modifier 53. The documentation must state that the physician actually started the procedure, why it was medically necessary to discontinue the procedure, and what percentage of the procedure he did perform.

Caution: Make sure you understand the difference between modifier 53 and modifier 52 (Reduced services).

Modifier 53: "Due to extenuating circumstances or those that threaten the wellbeing of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued," according to Appendix A in the CPT® manual. "This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure."

Modifier 52: On the other hand, modifier 52 normally applies when the physician plans or expects a reduction in services as represented by the CPT® code. This reduction of services must occur by choice (by either the physician or patient) rather than necessity (which falls under modifier 53). Reporting modifier 52 tells the payer that the physician completed the procedure, but not the full procedure as indicated by the code descriptor.

Resource: Read Cotiviti's complete audit details at www.cotiviti.com/cms-approved-issues-cotiviti.