Codify
BY AAPC

Outpatient Facility Coding Alert

Modifiers: Gain Auditor Insights on Discontinued Procedure Modifiers

Begin by getting all your documentation in order.

When a provider discontinues a procedure prior to the administration of anesthesia, it's important for you to know that the physician may still be entitled to some compensation. That's where your training as a coder comes into play. You've got to know what modifier is appropriate to append in the right situation.

According to the new audit issue posted by Part B Recovery Audit Contractors (RAC) Cotiviti on June 28, reviewers are looking at claims for procedures that are discontinued before anesthesia administration.

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 your 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 must 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 and anesthesia has not yet begun, 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) for the facility.

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.

The use of modifiers 53 and 52 were extended by CPT® during the last revision of upper GI endoscopy codes, Littenberg says. Modifier 53 can be used for a procedure not completed because, for example, there was too much residual food in the stomach and the patient will be brought back for another procedure after diet modification, he says. "Modifier 52 is supposed to be reported if, during procedures described by the 43235 family codes, the scope is not passed into the duodenum - or jejunum if patient has a gastroenterostomy. In neither type of modifier use should you reduce the usual fee; it will be payer discretion whether or how much to discount the procedure."

Resource: To read Cotiviti's complete audit details, visit https://www.cotiviti.com/cms-approved-issues-cotiviti.