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Modifier Coding Alert

Mind Your Modifiers: Unusual Anesthesia Calls for 23 in Your Repertoire

Prepare for the unplanned need for general anesthesia and enhance your coding.

You may not have a reason to use modifier 23 today but having it in your toolbox may improve your anesthesia coding tomorrow.

Your key to modifier 23 is identifying what makes anesthesia "unusual." Take a look at what clinical scenarios warrant the use of 23 so you are prepared when you need this modifier.

Couple 'Unusual' Anesthesia with 23

The modifier 23 descriptor is short, sweet, and to the point: Unusual anesthesia. The word "unusual" is why you may not often use this anesthesia modifier. CPT® Appendix A explains: "Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia." Using modifier 23 doesn't impact your reimbursement but having the information that a procedure wasn't normal is important to have in the records.

Do this: Before you use modifier 23, make sure the encounter meets these three criteria:

- Anesthesia is used when it's normally not necessary for the procedure
- Anesthesia is used because of unusual circumstances
- General anesthesia is used (instead of monitored anesthesia care [MAC]).

Define Why the Anesthesia is Unusual

Look in the notes to see what circumstance caused the need for anesthesia. For example, perhaps the physician opted for general anesthesia due to an underlying conditions such as Parkinson's disease (332.x, Parkinson's disease), mental retardation (317-319, Intellectual disabilities), claustrophobia (300.29, Other isolated or specific phobias), or cerebral palsy (343.x, Infantile cerebral palsy). Work with your physician so that she understands how important the documentation is in such circumstances.

The age and physical condition of a patient and the length of time the service is taking can also be reasons why your surgeon may use general anesthesia during a procedure when it normally isn't needed.

Example: A patient with neurocognitive disorder is seen by one of your gynecologists. The patient requires a pap smear (88174-88175, Cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation; ...) that normally does not require anesthesia. But due to the patient's neurocognitive condition and physical agitation, safety is a concern so your physician decides to use anesthesia, explains Jandroep.

If you don't put the neurocognitive disorder code 315.9 (Unspecified delay in development) on the claim, the payer may not see the medical necessity for the anesthesia and deny your claim.

The payer may review the diagnosis code and determine that it doesn't support the unusual circumstances modifier, says **Laureen Jandroep, CPC, CPC-H, CPC-I, CPPM, CMSCS, CHCI**, founder and CEO at CodingCertification.org in Oceanville, N.J. "A good review of what diagnoses are on the claim would be recommended."

Research the Payer Guidelines

Some payers may have their own guidelines for using modifier 23. Examples include:

- Listing modifier 23 in the second position and filing the claim with documentation
- Requiring modifier 23 to indicate a physician's presence for induction when used with modifier AD (Medical supervision by a physician: more than four concurrent anesthesia procedures)
- Requiring 23 to indicate that a vaginal or cesarean delivery lasted longer than four hours.

Appeal the claim: Knowing the rules doesn't lead to automatic acceptance, so you can find yourself appealing claims with modifier 23. When that happens, the notes need to emphasize the medical necessity for general anesthesia during the procedure. Also include a letter of medical necessity from your primary care physician or surgeon to help strengthen your appeal.