

THE CODE

The Official Medical Coding Newsletter of MiraMed, A Global Services Company

When to Apply Modifiers

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Part 1

Below are situations that you might encounter where you need to stop and ask yourself is a modifier necessary and which modifier to apply?

- Procedures either increased, reduced or discontinued (22, 52, 53 and facility 73, 74)
- Multiple procedures performed on the same day (50, 51, 59, if an E&M was done in conjunction with a procedure modifier 25)
- Procedures repeated on the same day (76, 77)
- Split or shared work of a surgical procedure between providers (62, 66)
- Patients have another surgery during a global period (58, 78, 79)
- The same procedure assisted by other surgeon or assistant (80, 81, 82, AS)
- Procedural service rendered in a particular location (i.e.: rural area, HPSA area, teaching facility)(QB, QU, GC)
- Procedure performed in a hospital setting (TC and -26 components)
- Non-covered procedures (GA, GX, GY, GZ)

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Modifier Usage

Let us now take a closer look at some of the modifiers keeping in mind that most providers outside of the Centers for Medicare & Medicaid Services (CMS) may have their own guidelines on how and when to apply modifiers given any of the above situations.

Modifier 22 – Procedures Either Increased, Reduced or Discontinued

The purpose of this modifier is to report services (surgical or nonsurgical) when the work required to provide a service is substantially greater than typically required. This modifier must be used only when additional work factors requiring the physician's technical skill involve significantly increased physician work, time and complexity other than when the procedure is normally performed.

- "Substantially Greater" refers to increased intensity, time, technical difficulty of procedure, severity of patient's condition and physical and mental effort required, etc.
- Trauma extensive enough to complicate the procedure and cannot be reported with additional procedures.

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Nothing great has ever been achieved except by those who dared to believe that something inside them was superior to circumstances.

Bruce Barton

The surest way not to fail is to determine to succeed.

Richard Brinsley Sheridan

When to Apply Modifiers *(continued from page 1)*

- Significant scarring (substantiated by a diagnosis) requiring extra time and work.
- Extra work resulting from morbid obesity or other unusual anatomic anomalies.
- Additional work and time involved in managing a patient's co-morbid conditions throughout the procedure.
- Increased time (substantiated by reason) resulting from extra work by the physician.

Example: A 55-year old female patient was admitted and a craniotomy performed for excision of a supratentorial brain tumor. The physician describes an additional 90 minutes of time was spent dissecting the tumor that had extended into the horns of the cistern. The CPT code reported by the physician would be 61510-22: Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma.

The documentation should reflect the extra problems, effort, extent or additional not-separately-codeable services that were required to treat the patient. The information can be documented anywhere in the note but should be sufficiently detailed that the additional time and/or complexity is clearly demonstrated. It is not sufficient to simply state that the procedure is a reoperation or a revision of a previous procedure, or simply document the extent of the patient's illness or co-morbid conditions that might cause additional work (the documentation must describe additional work performed); or state the specific skills and credentials of the provider that might make them uniquely qualified to perform the service.

Modifier 52 – Reduced Services

This modifier is used to report a service or procedure that is partially reduced or eliminated at the physician's election.

- Modifier 52 is appended to the code for the reduced procedure.
- Modifier 52 is not used to report an elective cancellation of a procedure before anesthesia induction and/or surgical preparation in the operating suite.
- Modifier 52 cannot be used if the procedure is discontinued after administration of anesthesia.

A 25-year old Medicaid patient desires permanent sterilization. After consultation with the physician, the patient elects to have a hysteroscopic approach. Following assessment of the uterine cavity and fallopian tubes, the physician successfully places the micro-insert in the right tube. The same procedure was initiated on the left. Multiple attempts were made to place the micro-insert on the left without success. The physician elects to terminate the procedure without accomplishing the implant on the left. The service is reported using CPT 58565-52: Hysteroscopy, surgical; with **bilateral** fallopian tube cannulation to induce occlusion by placement of permanent implants, but a 52 modifier is added because the procedure was successful only on the right fallopian tube. Clinical information documented in the patient's records must support the use of this modifier. Documentation should include a statement indicating in what way the procedure or service was reduced.

Modifier 53 – Discontinued Procedure

- Modifier 53 must be appended to a surgical code or medical diagnostic code when the procedure is discontinued because of extenuating circumstances. This modifier is used to report services or procedure when the services or procedure is discontinued after anesthesia is administered to the patient.
- This modifier is not used to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.
- Modifier 53 cannot be used when a laparoscopic or endoscopic procedure is converted to an open procedure.
- Modifier 53 cannot be appended to E/M codes.

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When to Apply Modifiers (continued from page 2)

Example: A 65-year old male high-risk Medicare patient was prepped for a diagnostic colonoscopy during which the provider was unable to pass the instrument past the splenic flexure due to fecal impaction. The procedure was stopped and reported with G0105-53: Colorectal cancer screening; colonoscopy on individual at high risk (per the Centers for Medicare & Medicaid Services (CMS) Program Memorandum, transmittal Ab-03-114, change request (CR) 2822). Reimbursement will be made on allowed amount for sigmoidoscopy.

CPT®, in contrast to CMS rules, instructs, “For an incomplete colonoscopy, with full preparation for a colonoscopy, use a colonoscopy code with the modifier 52 [*Reduced services*] and provide documentation.” Some non-Medicare payers may follow CMS guidelines for an incomplete colonoscopy (modifier 53), while others may adhere to CPT instructions (modifier 52). You will need to check with your individual third-party payers for their recommendations.

Clinical information documented in the patient's records must support to use of this modifier. Documentation must include a statement indicating at what point the procedure was discontinued. The extenuating circumstances preventing the completion of the procedure must also be documented.

Modifier 73 – Discontinued Outpatient Hospital Surgical Procedure/Service Prior to Anesthesia Administration

Used for surgical or radiological procedures in ASC. Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided and being taken to the room where the procedure is to be performed), but prior to the administration of the anesthesia.

- Used for procedures that require anesthesia.
- Used for an outpatient hospital procedure discontinued before the patient has been prepared for the procedure and/or before the induction of anesthesia whether local regional block(s) or general anesthesia.
- If none of the procedures were completed, report the first planned procedure with modifier 73.

Patient must be wheeled to the room where the procedure is to be performed in order to report modifier.

- Do not use this modifier for the elective cancellation of a procedure.
- Do not use this modifier if the surgeon cancels or postpones the scheduled surgery because of a patient complaint such as a cold or flu upon intake.
- The physician should not use this modifier. This is only appropriate for use by the ASC.

Example: A 65-year old male was brought to the OR for repair of a recurrent inguinal hernia. The patient was prepped and draped and positioning was carried out. Before the administration of anesthesia, the patient complained of chest pain. A cardiac monitor revealed ST segment changes. The procedure was cancelled and the reported CPT 49520-73: Repair recurrent inguinal hernia, any age, reducible.

Modifier 74 – Discontinued Outpatient Hospital Surgical Procedure/Service After Anesthesia Administration

Used for surgical or radiological procedures. Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia or after the procedure was started (incision made, intubation started, scope inserted.)

- Used for procedures requiring anesthesia.
- Used for an outpatient hospital/ambulatory surgery center (ASC) or diagnostic procedure discontinued after the patient has been prepared for the procedure and/or after the induction of anesthesia whether local, regional block(s) or general anesthesia.

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When to Apply Modifiers (continued from page 3)

- Multiple procedures:
 - If one or more procedures were completed- only report completed procedures.
 - If none of the procedures were completed, report the first planned procedure with modifier 74.
- This modifier is not appropriate for the elective cancellation or postponement of a procedure based on the physician or patient's choice.
- This modifier is not appropriate when the termination of the procedure occurs prior to the beginning of the procedure or the administration of anesthesia.
- This modifier is not for physician use. It is only appropriate for the ASC.
- The operative report and documentation should include the following:
 - Reason for termination of the surgery,
 - Services actually performed,
 - Supplies actually provided,
 - Services not performed that would have been performed if surgery had not been terminated,
 - Supplies not provided that would have been provided if the surgery had not been terminated,
 - Time actually spent in each stage, e.g., pre-operative, operative and post-operative,
 - Time that would have been spent in each of these stages if the surgery had not been terminated, and
 - HCPCS code for procedure had the surgery been performed.

Example: A 65-year old male was taken to the OR for a laparoscopic cholecystectomy. After the portal entry incision was made, it was noticed by the anesthesiologist that the patient was in ventricular fibrillation on the cardiac monitor. Defibrillation ensued X 2 which resulted in abatement of the arrhythmia. The procedure was cancelled pending a cardiac consult. The CPT reported for the cancelled procedure would be 47562-74: Laparoscopic surgical cholecystectomy.

To be continued in next issue....

NOTICE!

AHIMA ICD-10 Exam Delay (effective April 1, 2014)

CCA – April 1, 2015

CCS-P – April 14, 2015

RHIA – April 21, 2015

RHIT – April 28, 2015

Although a starting date has not been communicated on the ICD-9 Exam, AHIMA has communicated the last date the exams will be available in ICD-9:

CCA – March 31, 2015

CCS-P – April 13, 2015

RHIA – April 20, 2015

RHIT – April 27, 2015

If you have a question, comment or suggestion regarding the content of *The Code*, please send an e-mail to either denise.nash@miramedgs.com or evan.ramos@miramedgs.com.

May Coding Case Scenario

By: Evan Lendle Ramos, RN, CCS

Senior Manager, Auditing and Training Services, Miramed Philippines Group, LLC—Philippine Branch

Each month MiraMed will offer a coding question for our staff to solve. If you'd like to quiz yourself, feel free. We will gladly let you know the results of your guess. The first coder from each Team (Philippines and India) who correctly answers will be given a prize and recognition on the next issue of our newsletter.

Question:

Code the following case scenario using your ICD-9-CM book for diagnoses and CPT book procedure(s).

Ambulatory (Facility) Health Record: A 45-year old female patient presents for wide excision of a 2.0 cm malignant melanoma of the right posterior calf. The area excised resulted in a 4.3 cm x 2.5 cm defect requiring rotational advancement flap closure. The pathology report shows clear margins.

What are the correct codes to report? The procedure is performed in the outpatient surgery suite at the hospital.

Email your answers to evan.ramos@miramedgs.com and denise.nash@miramedgs.com.

Correct Answer from our April Case Scenario:

Principal Diagnosis – 414.01-Y

Secondary Diagnoses – 411.1-Y, 496-Y, 415.11-N

Principal Procedure – 36.12

Secondary Procedure – 36.15, 39.61

Rationale:

In accordance with UHDDS guidelines for principal diagnosis assignment, the ASHD is the reason for admission and is sequenced as principal diagnosis. (*ICD-9-CM Official Coding and Reporting*)

Not all conditions that occur during or following medical care or surgery are classified as complications. Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.

Query the provider for clarification if the complication is not clearly documented.

**Last Month's Winner:
CONGRATULATIONS!!!!**



John Christian Sayo
IP Auditor Trainee