Discontinued Services

BY CINDY PARMAN, CPC, CPC-H, RCC

Sometimes patients present for infusion or radiation therapy but for one reason or another therapy cannot be completed. The aborted treatment may be due to patient contraindication, equipment malfunction, or reaction to the medication administered, but it also may represent a billable service. Setting of care is important when billing as there are often significant differences in coding and reimbursement for hospitals and freestanding cancer centers.

Hospital Modifier

A significant change that affects hospital billing for cancelled procedures was published in the January 2012 update to the Outpatient Prospective Payment System (OPPS). From 2005 until January 2012, modifier 52 was reported for "partial reduction or discontinuation of services for which anesthesia is not planned." The *CPT® Manual* defines this modifier as:

> "Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service."

For example, if an outpatient hospital patient presents for radiation therapy, is placed on the treatment table, receives part of the prescribed dose, and the treatment machine ceases to function, the treatment delivery code can be charged with modifier 52 to report this abbreviated service. This is a partial-treatment-delivery service, a procedure that does not require anesthesia, appropriately appended with the reduced services modifier. However, effective Jan. 1, 2012, the Centers for Medicare & Medicaid Services (CMS) has re-defined modifier 52 in the hospital outpatient setting (emphasis added):

> "Modifier 52 is used to indicate partial reduction, *cancellation,* or discontinuation of services for which anesthesia is not planned."

CMS guidance states that the use of modifiers provides a way for hospitals to report and be reimbursed for expenses incurred in preparing a patient for a procedure and scheduling a room for performing the procedure when the service is subsequently discontinued *or cancelled*. The Medicare Claims Processing Manual, Chapter 4, 20.6.4 states:

> "Procedures for which anesthesia is not planned that are discontinued, partially reduced or *cancelled* after the patient is prepared and taken to the room where the procedure is to be performed will be paid at 50 percent of the full OPPS payment amount. Modifier 52 is used for these procedures."

This change in modifier description applies only to Medicare patients and only then for outpatient hospital services. For example, a Medicare patient presents for drug administration, is prepared for treatment, and the port is accessed. Prior to drug delivery, however, the patient experiences dizziness, nausea, and fever. The physician decides that the medication cannot be administered, and the patient is rescheduled for administration at a later date. Based on the revised Medicare guidelines, the hospital can charge for the cancelled procedure and the discarded drug. This change does not mean that all codes for the planned administration service can be charged; the hospital would report one drug administration code with modifier 52 and the discarded drug amounts. Note: there is still no charge for "no show" patients or services that are cancelled prior to patient preparation.

CMS publishes a list of modifiers that may be reported by hospitals under the OPPS in the Medicare Claims Processing Manual, Chapter 4, Section 20.6.2. Note: modifier 53 used by physician offices to report discontinued services is never reported in the hospital outpatient setting.

Physician & Freestanding Center Modifier

While the hospital uses modifier 52 to report services that are partially reduced, the physician and/or freestanding cancer center (non-provider-based facilities) report a different modifier for discontinued services. The *CPT® Manual* lists the following modifier description:

> "Modifier 53, Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. 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. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure."

Modifier 53 is correctly reported for instances where the procedure must be

discontinued for patient health reasons, due to equipment malfunction, or for other extenuating circumstances that prevent the completion of the service—in essence unexpected problems encountered that are beyond physician or patient control. The physician does not choose to discontinue the procedure, but is forced to abort the service due to extenuating circumstances. The physician or non-provider-based cancer center can only report a procedure code with modifier 53 when the service has been initiated but could not be completed. Services that are cancelled where no portion of the procedure has been performed are not separately charged.

For example, a patient scheduled for radiation treatment is placed on the treatment couch, but the therapy must be discontinued due to machine malfunction. In the freestanding center or physician office setting, this discontinued service would be reported with modifier 53. A critical difference is that the physician or freestanding cancer center cannot report a charge for a service that was cancelled without any portion of the drug administered or the radiation delivered (see Table 1).

Of note, the physician office or non-provider-based cancer center can also use modifier 52 when the physician elects to partially reduce or eliminate a portion of a procedure. In this instance, at least part of the service has been performed when the physician decides to partially reduce or eliminate the procedure. This scenario does not typically occur when oncology services are performed.

Documentation & Coding

Regardless of practice setting, documentation in the medical record must include specific information about the medical condition(s) or other extenuating circumstance that led to cancellation or a reduced service. This documentation is critical to support both the resources expended prior to cancellation or termination of the service and the specific patient contraindication(s) or equipment issues responsible for the cancellation of the procedure.

Remember that drug administration services may be coded and billed for the amount of time the drug was actually administered. For example, if the drug infusion is initiated and the patient only tolerates 15 minutes of administration, coding guidelines state that this service would be reported with the code for an intravenous push. A reduced services or discontinued services modifier would not be reported with this code, but the appropriate diagnosis codes would be included on the claim form.

Patient no shows, forgotten appointments, etc., are not separately charged in any practice setting; these circumstances do not meet the Medicare definition of a cancelled outpatient procedure. Modifier 52 is intended to be reported by the hospital when the patient presents and is prepared for treatment, but it is not delivered because of extenuating circumstances. The same is true for services performed in a non-provider-based facility; there are no charges for missed appointments.

In addition, diagnosis coding should accurately describe the patient's medical condition. For example, a Medicare patient presents to the hospital for IMRT to the prostate, but feels dizzy as he is climbing on the treatment couch. The nurse takes his blood pressure and notes that it is unusually high. The physician recommends that the patient discontinue treatment and has the patient transferred to the hospital's emergency department. The diagnosis codes for this encounter are:

- **V58.0:** Encounter for radiation therapy
- **185:** Malignant neoplasm of the prostate
- **780.4:** Dizziness
- **796.2:** Elevated blood pressure reading without diagnosis of hypertension
- **V64.1:** Surgical or other procedure not carried out because of contraindication.

Diagnosis codes tell the patient's story and when a procedure is cancelled or terminated, it is important to tell the entire story. While the aborted IMRT treatment would be reported by the hospital with procedure code **77418-52,** the inclusion of all necessary diagnosis codes ensure that the reason for the discontinued procedure is also reported.

Remember: only the hospital can report a cancelled procedure after patient preparation; this service would not be billed if it occurred in a non-provider-based facility. To bill for the procedure in an office setting, the patient would have to receive at least part of the treatment. OI

—Cindy Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc., in Powder Springs, Ga.

Table 1. Coding for Discontinued Services

SCENARIO	HOSPITAL	PHYSICIAN OFFICE
Patient calls and cancels treatment	No Charge	No Charge
Patient is a "no show" for the scheduled service	No Charge	No Charge
Patient prepped for treatment, but no portion of care delivered due to patient contraindication	Modifier 52	No Charge
Patient receives part of drug administration or radiation treatment, but service is terminated due to contraindication	Modifier 52	Modifier 53
Physician plans to perform only part of service described by procedure code	Modifier 52	Modifier 52