Codify
BY AAPC

# Dermatology Coding Alert

## You Be the Coder: Don't Forego Discontinued-Procedure

**Question:** When my physician discontinues a procedure, I'm never certain how to bill for it. When can I bill for stopped procedures, and how should I decide between modifiers 52 and 53?

**Answer:** In practice, there's enough overlap between modifiers 52 and 53 to cause continued confusion on how to apply them.

**Keep 52 for Unplanned Reductions**

Modifier 52 (Reduced services) applies when "a service or procedure is partially reduced or eliminated at the physician's discretion," according to CPT's Appendix A, "Modifiers." You should use modifier 52 when "services are less than described by the code," says **Pamela J. Biffle, CPC, CCS-P, ACS-DE**, director of operations for AAPC e-Learning headquartered in Salt Lake City. "You don't have to plan on services being reduced to use modifier 52. Often the provider may not know until the service has started."

**Alternatively:** You should append modifier 53 (Discontinued procedure) if the physician elects to terminate a surgical or diagnostic procedure "due to extenuating circumstances or those that threaten the well-being of the patient," according to CPT instructions. Generally, however, if the physician plans or expects a reduction in services, or if the physician electively cancels the procedure, modifier 52 is appropriate.

**Example:** If a descriptor specifies a bilateral procedure but no code describes an equivalent unilateral procedure, and the physician provides the service on one side only, modifier 52 is appropriate. In such a case, you must be certain that there is no designated CPT code to describe the lesser procedure.

**Unexpected Complications Warrant 53**

In contrast, if the physician reduces the service due to unexpected complications that place the patient at unacceptable risk, modifier 53 is appropriate. "The 53 modifier is used when the procedure was started and then is reduced because of extenuating circumstances," says **Suzan Hvizdash, CPC**, physician educator for the University of Pittsburgh and past member of the American Academy of Professional Coders National Advisory Board. That is, the physician intended to provide the complete service but was unable to do so because of unusual or complicating circumstances that threatened the well-being of the patient.

For example, a physician providing a surgical service may abandon the procedure due to extensive hemorrhaging or adverse reaction to anesthesia. In this case, modifier 53 is appropriate. In another scenario, the physician elected to stop the service because of an uncooperative patient, not because of any undue risk of harm to the patient. Therefore, modifier 52 is more appropriate than 53.

**Caution:** You cannot use modifier 53 unless anesthesia has already been initiated, Biffle says. If the physician cancels a procedure prior to anesthesia, you cannot bill the surgical procedure code even with modifier 53 appended. Instead, if the physician performs and documents a history, an exam, and/or some level of medical decision-making (two of the three), you should bill the appropriate inpatient or outpatient E/M service code.

**Example:** A patient arrives to pre-op with her blood sugar at 360. This is an unacceptable level for the patient to undergo surgery. An endocrinologist is called to pre-op and starts the patient on an insulin drip, but the patient's blood sugar level doesn't drop sufficiently, so the surgeon decides it is in the best interest of the patient's well-being to cancel surgery. Although the surgery was canceled due to the well-being of the patient, she was never put under anesthesia, so

you should bill an E/M service code based on the physician's documentation.

**Check Completion Level for Guidance**

**Additional modifiers:** In an ambulatory surgery center, the facility reports the appropriate surgical procedure code for the case. And the facility appends modifier 73 (Discontinued outpatient procedure prior to anesthesia administration) or modifier 74 (Discontinued outpatient procedure after anesthesia administration), depending on when the physician canceled the case, Hvizdash says.

**Pointer:** Another way to tell if the service needs a 52 or a 53 is to consider if the patient had the entire service the physician intended to provide.

Use modifier 53 if the surgeon discontinued the procedure without completing the treatment as planned. Use modifier 52 if the service is complete. Although not foolproof, this method is very consistent in identifying which modifier to use.

When appending either modifier, provide documentation with the claim explaining the reason your physician reduced or terminated the service. Do not reduce your fee. Instead, allow the payer to make a reimbursement decision based on documentation. Docu-mentation should also contain an estimation of the total percent of the procedure that the physician performed and completed.

**Bonus:** When you bill a discontinued surgery using modifier 53, you can then bill that same surgical code when the actual surgery is accomplished. You cannot do that with modifier 52.