Internal Medicine Coding Alert

You Be the Coder: Unsuccessful Procedure Attempt

Question: How should I bill for an unsuccessful procedure attempt? My internist attempted 36410 but couldn't access the vein. Should I use a modifier or some other code to signify to the insurance company that the doctor attempted the procedure but failed?

Colorado Subscriber

Answer: You will commonly use one of two modifiers in these situations. Modifier 52 (Reduced services) indicates that a physician partially reduced or eliminated part of a procedure at his or her discretion. Modifier -53 (Discontinued procedure) identifies a procedure that the doctor terminates due to extenuating circumstances or circumstances that create risk for the patient.

In your scenario, the internist completed the procedure unsuccessfully - he didn't obtain a sample.

Consequently, you should report 36410* (Venipuncture, child over age 3 years or adult, necessitating physician's skill [separate procedure], for diagnostic or therapeutic purposes. Not to be used for routine venipuncture). The physician completed the procedure, but without success. Therefore, you don't need to attach a modifier.

In contrast, if the internist performs only part of a procedure and the CPT code describes a larger service, you would append modifier -52 to the procedure code. For instance, your internist gives a patient 50 mg of Demerol (J2175), even though J2175 calls for 100 mg. You would append -52 to 99211 (Office visit).