Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

5 Easy Billing Tips for Modifiers 52 and 53

File preparation and clear documentation are the keys to getting these claims paid

When you're reporting codes appended with modifiers 52 (Reduced services) and 53 (Discontinued procedure), use these quick methods from coding experts to help ensure your claims will be paid.

1. Prepare for modifier 53 documentation requests. Because modifier 53 and some modifier 52 claims involve varying circumstances, payers' systems could kick them out, and they will review them manually. HIPAA, however, requires that you file all claims electronically, which means you may have to wait for the denial and/or "request for additional information" from the insurer before you can send in your documentation.

Have the copies ready in a separate file when you submit the claim, knowing that the carrier will deny the claim or request further information.

2. Provide detailed, accurate and easily understandable documentation. The reviewer who is reading your claim's supporting documents will likely not be a clinician. Consequently, your documentation should be put in terms a layperson can understand. You may want to include a special summary report that describes the patient's condition, what the planned procedure was, what the extenuating circumstances were, what actually happened because of the patient's condition, and what time and effort was involved. This summary shouldn't be more than a few paragraphs, with the first paragraph detailing the procedure's medical necessity and the second noting what was planned and why it was discontinued.

3. Identify Risk to Patient Before Using Modifier 53. Before you submit a claim with modifier 53, identify the documentation that indicates the circumstances that threaten the well-being of the patient. Extenuating circumstances around which your physician would discontinue a procedure might be:

- Respiratory distress
- Hypoxia
- Irregular heart rhythm
- Issue related to the anesthesia.

Example: A pain physician begins a left C3-C4 radiofrequency facet denervation procedure with fluoroscopic guidance and has placed the cannula. Before the actual denervation can take place, the patient develops respiratory distress and the procedure must be aborted. In this case, you would report 64633 (Destruction by neurolytic agent, paravertebral facet joint nerve[s], with imaging guidance [fluoroscopy or CT]; cervical or thoracic, single facet joint) with modifier 53

4. Document, document, document. Explicit documentation, involving the reason for termination as well as the interventions provided to stabilize and/or resolve the condition, can help ensure appropriate reimbursement when extenuating circumstances occur -- which is often the case when you're reporting modifiers 52 and 53. Everything has to be recorded so you can justify reporting the modifiers and ensure proper reimbursement for the work performed.

5. Don't confuse reduced services with reduced charges. Most payers don't require you to reduce your fees when filing a claim with modifier 52. Payers will often see the modifier and automatically reduce the reported fee based on the amount of work you actually performed. The documentation you provide will help the carrier determine the appropriate reduction. If you're not sure exactly how to bill, contact the payer and ask for help.