Part B Insider (Multispecialty) Coding Alert

Grasp the Difference Between Modifiers -52 and -53

Follow These Strategies for Billing Incomplete Procedures

If your physician has to stop doing a procedure for some reason, your whole reimbursement just went down the tubes, right? Wrong!

Many coders and administrators don't understand the rules for billing for incomplete procedures - whether to bill an unspecified-procedure code or the code for a complete procedure plus a modifier. And there's the fact that there are two modifiers for incomplete procedures, -52 (Reduced services) and -53 (Discontinued procedure). Here are some handy tips:

-52 is for the physicians' decision to reduce a service. For example, the physician only performs part of the procedure and then stops, says consultant **Sheldrian Wayne** with **Coding Strategies Inc.** in Powder Springs, Ga. The physician either decided in advance to curtail the procedure or realized halfway through the procedure that he or she couldn't conclude it.

The patient may have received anesthesia and an incision, but the physician didn't completely conclude the procedure, Wayne says.

This modifier doesn't necessarily mean the physician decided to stop a procedure halfway through, says **Mary I. Falbo**, president of **Millennium Healthcare Consulting Inc.** in Lansdale, Pa. A physician may decide in advance to do a partial removal of something where the code describes a total removal, or removing one ovary instead of both.

Radiologists use modifier -52 for circumstances in which the physician bills for a supervision and interpretation but the physician only performed an interpretation without supervision, Wayne says. In that case, you'd append the -26 modifier for the professional component, and the -52 modifier for the incomplete procedure. This works with almost any radiological code that has professional and technical components.

-53 is for procedures that the physician terminates because of external circumstances. For example, the patient's blood pressure is dropping, Falbo says. Or the physician tries to remove a tumor, then realizes the tumor is too widespread to remove safely.

"If the patient's well-being is threatened, that's really the key thing," Wayne says. "There's going to be some extenuating circumstance."

In some cases, if a physician performs a partial procedure instead of a complete procedure, you may want to use an unlisted-procedure code instead of the code for the complete procedure plus a modifier, Falbo says. This applies more in cases in which the partial procedure has no CPT Codes.

Depending on your carrier and your local fee schedules, the reimbursement for a procedure using either of those modifiers may be greatly reduced. It may not seem fair if a physician does as much work on an incomplete procedure as on an incomplete one, but only receives half as much money. In that case, Wayne and Falbo both advise writing to the carrier explaining the circumstances "in layman's terms."

If a procedure fails, the physician may have to perform the same procedure again, within the first procedure's global

period. In that case, you should bill with modifier -76 (Repeat procedure by same physician), or modifier -77 (Repeat procedure by another physician) if it's a new physician.

If the procedure leads to complications and the physician has to cope with those, you'd use modifier -78 (Return to operating room ...).