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Part B Insider (Multispecialty) Coding Alert

MODIFIERS: Learn The Cure For 52/53 Modifier Headaches

Document the reason for a discontinued or reduced procedure

An incomplete procedure doesn't have to equal zero reimbursement. Master the 52 and 53 modifiers, and you can reap the rewards.
Many coders get confused between the 52 and 53 modifiers. Here's the difference, according to **Carol Pohlig**, a senior coding and education specialist with the **University of Pennsylvania's** medicine department in Philadelphia:

• The **52 modifier** (Reduced services) is for an "elective" situation. In other words, the physician **chooses** not to go any further with the procedure because the procedure has already achieved its objective, says Pohlig. Also, the physician could end the procedure because she's already gathered all the information she needed. There's no medical reason not to continue the procedure, but there's no need to.

Example: A CPT code calls for a procedure to be performed over a 24-hour period, but the physician only spends 12 hours on it, says **Dianne Wilkinson**, compliance officer and quality manager with **MedSouth Healthcare** in Dyersburg, TN. She uses the 52 modifier frequently for preventive examination codes when documentation shows just a pap smear and the pelvic/breast exam, instead of the comprehensive work those codes call for.

Warning: Don't use the 52 modifier in cases where the physician performed a different procedure that doesn't have its own CPT code, Pohlig warns. Some coders may be tempted to use the 52 modifier with an existing code if the procedure is similar to a portion of an existing procedure. But CPT rules require you to use an unlisted code instead, Pohlig warns.

• The 53 modifier (Discontinued services) is for situations where the physician sees some risk that the patient's health could be threatened if the procedure continues, says Pohlig.

Example: A doctor is performing a colonoscopy on the patient, but the patient's anatomic structure turns out to be "tortuous," and the doctor isn't prepared to deal with it. To continue the procedure would put the patient at risk for perforation. The patient doesn't have to experience a side effect of the procedure, such as failing to tolerate the anesthesia.

Pay attention: In the facility setting, you use a separate set of modifiers, the 73 and 74 modifiers, for discontinued and incomplete procedures, says Pohlig. When you use those facility modifiers, you can report services whether or not the patient had started anesthesia. But you can **only** use the 52 and 53 modifiers if the procedure had already started, including the provision of anesthesia.

In fact, you shouldn't bill for a procedure if the patient just received anesthesia, unless your doctor is the anesthesiologist, Pohlig notes. You should only bill for the procedure if your doctor actually started performing his or her part.

Submit Complete Documentation

In the past, Pohlig recommended that claims with the 52 or 53 modifiers should "drop to paper" so you could submit a written explanation with the claim. But in the new age of HIPAA and electronic standards, you must bill electronically first.

Once you bill electronically with either the 52 or 53 modifier, the carrier will request more information, says Pohlig. If your physician is documenting properly, the operative note should contain all the information the carrier needs.

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"If you had a failed procedure, the op note should state why, and what failed," says **Lisa Center,** quality review coordinator for the **Freeman Health Center** in Joplin, KS. And if the doctor discontinued the procedure due to the patient's condition, the op note should detail what factors prevented the procedure from going forward.

If you do feel the need to include a cover letter explaining why the procedure didn't go forward, your physician should write it personally, Pohlig adds.

If your patient had an adverse response to the anesthesia, including vomiting or nausea, you should include your nurse's report on these symptoms, advises **Maxine Lewis** with **Medical Coding Reimbursement Management** in Cincinnati.

Important: Make sure your cover letter or documentation spells out clearly exactly how far the physician progressed. Don't leave it up to the carrier to decide how much reimbursement you're owed, Lewis advises.

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