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Part B Insider (Multispecialty) Coding Alert

Modifiers: Utilize 52, 53 for Stopped Surgery Claims

Caution: Know the particulars on modifier 53 to avoid denials.

Occasionally, surgeons need to stop surgeries, and it's critical that you know how to deal with and code a "stopped surgery" claim. That way, you might be able to utilize a pair of modifiers to get partial payment for services rendered.

Which ones? Modifiers 52 (Reduced services) and 53 (Discontinued procedure) are for use when the provider must stop performing a service. Which one you use, and when, is the biggest challenge for coders.

There are other challenges, too; getting modifier 52/53 claims paid can be a pain, but it can also be worthwhile if you get all the reimbursement you're entitled to for the stopped service. Read on for the info you need on modifiers 52 and 53.

Opt for Modifier 52 When Physician Stops Service

"Modifier 52 indicates that a service was partially reduced or eliminated at a physician's discretion," explains **Mary I. Falbo, MBA, CPC**, CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania. This often occurs when a physician performs a bilateral procedure on one side only; for these services, you'll append modifier 52. "However, if the code description includes 'unilateral or bilateral,' do not append modifier -52," Falbo continues.

Also, if a provider plans or expects a reduction in the service, or electively cancels the procedure prior to completion, you should append modifier 52 to the appropriate CPT® code. Per Appendix A in the CPT® manual: "Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52,' signifying that the service is reduced."

One other way you might employ modifier 52 is for a procedure where the provider doesn't perform all the components of the procedure, relays **Marcella Bucknam, CPC, CCS-P, COC, CCS, CPC-P, CPC-I, CCC, COBGC**, revenue cycle analyst with Klickitat Valley Health in Goldendale, Washington. "The most frequent use that I've seen is when a patient has surgery and the surgeon does not close the wound, either because the wound is going to be allowed to heal by secondary intent or because they are planning to bring the patient back to the OR [operating room] and do another procedure and then close the wound at that time," she explains.

Use Modifier 53 in These 3 Circumstances

While there are a couple of exceptions, there are three specific circumstances in which you'll most often apply modifier 53, Bucknam explains:

- "After anesthesia was induced, the patient developed a complication that required the procedure to be stopped - for example, due to a drop in blood pressure.
- "After anesthesia was induced, the physician developed a problem and could not go on. I've only seen this one time, when the surgeon cut his hand during the procedure.
- "After anesthesia was induced, it was discovered that a key piece of equipment was not working correctly and the procedure could not be continued."

These stops in services are usually termed "unexpected" or "due to risk" cancellations. Again, per Appendix A in CPT®

2021: "Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier '53' to the code reported by the physician for the discontinued procedure."

Rely on 52/53 Documentation Template

According to Falbo, the Centers for Medicare & Medicaid Services (CMS) calls for the following documentation on modifier 52/53 claims:

- A brief explanation for the reduction and/or discontinuation of service.
- Complete documentation of the reason for reduction retained in the patient's record.
- Procedure start time.
- Procedure stop time.
- Explanation as to why the procedure was discontinued.
- An estimate of the percentage of the procedure that was performed.

This info seems pretty straightforward, but Bucknam warns coders not to take for granted that their provider included all the relevant information in order to ensure modifier 52/53 claim payment.

"Usually the documentation is self-evident: Only one side was done on a bilateral procedure; the procedure had to be stopped because the patient's heartbeat was irregular; the abdomen was not closed after a procedure was performed, etc.," she explains.

"However, the coder should be careful to verify that the documentation is complete. I've seen situations where the surgeon got interrupted during his dictation and didn't state he had closed the abdomen or treated the other side. That required an amendment, not a modifier," says Bucknam. "Typically, if that decision is made the surgeon will document that the wound was covered and would be allowed to heal by secondary intent or that the patient would be returning to the OR … to make it clear that the documentation is complete."