Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Do You Know the Difference Between Modifiers -52 and -53?

Hint: Uncovering why the physician halted the procedure is the key to defining reduced services

If you're using modifiers -52 and -53 interchangeably, you're making a big mistake. These two modifiers indicate very different reasons for a less-than-total service, and coders can make the correct choice by asking themselves, "Why did the physician stop the procedure?"

If Planned or Electively Reduced, Choose -52

When 1) the surgeon plans or expects a reduction in the service, or 2) the surgeon electively cancels the procedure prior to completion, you should append modifier -52 to the appropriate CPT code.

Modifier -52 (Reduced services): When a service or procedure is partially reduced or eliminated at the physician's discretion, coders should identify the service provided by its usual procedure number and the addition of the modifier -52. The modifier signifies to the payer that the service is reduced (CPT 2004, Appendix A).

To apply modifier -52, the reduction of services must have occurred by choice (either the surgeon's or the patient's) rather than necessity.

"For example, the surgeon may determine that it is appropriate to provide the service at a lesser level than the complete description indicates, or the patient may elect to cancel the procedure," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for CRN Institute, an online coding certification training center based in Absecon, NJ.

Example A: The surgeon performs a pelvic lymphadenectomy on the right side. In this case, because CPT does not contain a code describing unilateral lymphadenectomy, you should report **CPT 38571** (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy) and append modifier -52 to describe a reduced service.

Example B: The surgeon begins colonoscopy (45378, Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen[s] by brushing or washing, with or without colon decompression [separate procedure]), which includes an exam of the entire colon, from the rectum to the cecum (and possibly into the ileum). During the exam, however, the surgeon finds he cannot advance the examination beyond the splenic flexure. In this case, you should report 45378-52 to denote the "reduced" service, according to CPT guidelines.

Note: The example above applies to non-Medicare payers. Medicare stipulates unique guidelines concerning incomplete colonoscopy, and recommends reporting 45378-53 rather than 45378-52. Although this runs directly contrary to CPT's specific instructions, you must follow Medicare guidelines to receive payment from Medicare payers.

If the Patient Is at Risk, Append -53

When the physician terminates a procedure because continuation of that procedure puts the patient's health at risk, you should append modifier -53 to the appropriate CPT code. You should **not** append modifier -53 if the surgeon electively cancels a procedure prior to the administration of anesthesia or surgical preparation in the operating room, according to CPT guidelines.

Modifier -53 (Discontinued procedure): Due to extenuating circumstances or those that threaten the well-being of the patient, a physician sometimes must terminate a surgical or diagnostic procedure mid-way through. This

circumstance may be reported by adding the modifier -53 to the code reported by the physician for the discontinued procedure (CPT 2004, Appendix A).

"Modifier -53 describes an 'unexpected problem,' beyond the physician's or patient's control, that necessitates the termination of the procedure," says **Carol Pohlig, BSN, RN, CPC**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia. "The physician doesn't so much elect to discontinue the procedure as he or she is forced to do so."

In addition to circumstances that put the patient's health at risk, you might also choose modifier -53 if the surgeon must halt the procedure due to equipment failure or because he cannot go on (for example, the surgeon cuts himself and cannot continue).

Example C: The patient arrives in the operating suite for repair of an abdominal aneurysm (35081, Direct repair of aneurysm, pseudoaneurysm, or excision [partial or total] and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta). While the surgeon attempts to access the aneurysm, the patient develops significant cardiac arrhythmia.

Although the anesthesiologist works to control the premature ventricular contractions, the surgical team decides to discontinue the procedure because of the potential risks to the patient. In this case, you should report 35081-53. You should include an operative note explaining why the surgeon discontinued the procedure and what percentage of the surgery he completed.

Example D: The surgeon begins a laparoscopic colectomy (44210, Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy). The patient has received anesthesia, but prior to creating the incision, the surgeon has problems with the camera. Because of mitigating factors, the surgeon cannot convert to an open procedure. The surgeon abandons the procedure and reschedules for a later date. You should report 44210-53 and include documentation with the claim.

If You're Cutting Fees for -52 And -53, You're Losing Out

If you're appending modifier -52 or -53 to a claim, you want to tell the payer why. Include a cover letter as well as the operative report with your claim to explain the extenuating circumstances that caused the physician to reduce or discontinue the procedure, Jandroep says.

For instance, if the patient becomes uncooperative, you should note this as the reason for terminating the service (for instance, "During colonoscopy, the patient wished to discontinue the procedure due to discomfort."). Or, if the patient becomes dangerously unstable during a procedure, you should explain these conditions as well (for example, did the patient's blood pressure rise suddenly? Did he begin to convulse? What exact symptoms led to the discontinuation of the service?).

"The rules of medical necessity don't go out the window just because you append -52 or -53," Jandroep warns.

Don't Lower Your Fees

You should never lower you fees when submitting a claim with modifier -52 or -53. Rather, you should provide as much documentation and explanation as possible and allow the payer to make a determination based on the information you submit, Jandroep says.

"If you reduce your fee up front, the payer may take an additional reduction on top of that. Additionally, remember that the fees you charge become part of a database of reasonable and customary fees. If you submit a reduced fee, that can distort the collected data," Jandroep says.

You should also consider that a terminated procedure might not necessarily mean less effort than a completed procedure. If the physician makes several unsuccessful attempts to perform colonoscopy, for instance, he may actually work harder than if the procedure had gone as planned. This is also true if you are dealing with a difficult or younger patient who refuses to complete a procedure.

Codify
BY AAPC