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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Forego Discontinued-Procedure Pay Due To Modifier Confusion

Get straight on modifiers 52 and 53

When your physician discontinues a procedure, are you certain how to bill for it? If you-re wondering when you can bill for stopped procedures--and how to decide between modifiers--you-re not alone.

In practice, there's enough overlap between modifiers 52 and 53 to cause continued confusion on how to apply them. Read the following guidance to clear the cobwebs on this tricky distinction.

Keep 52 for Unplanned Reductions

Modifier 52 (Reduced services) applies when -a service or procedure is partially reduced or eliminated at the physician's discretion,- according to CPT. You should use modifier 52 when -services are less than described by the code,- adds **Pamela J. Biffle, CPC, CCS-P, ACS-DE**, director of operations **for AAPC e-Learning** headquartered in Salt Lake City. -You don't have to plan on services being reduced to use modifier 52. Often the provider may not know until the service has started.-

Alternatively: Append modifier 53 (Discontinued procedure) if the physician elects to terminate a surgical or diagnostic procedure -due to extenuating circumstances or those that threaten the well-being of the patient,- according to CPT. Generally, however, if the physician plans or expects a reduction in services, or if the physician electively cancels the procedure, modifier 52 is appropriate.

Example: If a descriptor specifies a bilateral procedure but no code describes an equivalent unilateral procedure, and the physician provides the service on one side only, modifier 52 is appropriate. In such a case, you must be certain that there is no designated CPT code to describe the lesser procedure.

Unexpected Complications Warrant 53

In contrast, if the physician re-duces the service due to unexpected complications that place the patient at unacceptable risk, modifier 53 is appropriate. -The 53 modifier is used when the procedure was started and then is reduced because of extenuating circumstances,- says **Suzan Hvizdash, CPC**, physician educator for the **University of Pittsburgh** and former AAPC National Advisory Board member. That is, the physician intended to provide the complete service but was unable to do so because of unusual or complicating circumstances that threatened the well-being of the patient.

Example: A physician providing a surgical service may abandon the procedure due to extensive hemorrhaging or adverse reaction to anesthesia. In this case, modifier 53 is appropriate. But if the physician elected to stop the service because of an uncooperative patient, not because of any undue risk of harm to the patient, modifier 52 is a better fit than 53.

Caution: You cannot use modifier 53 unless anesthesia has already been initiated, Biffle says. If the physician cancels a procedure prior to anesthesia, you cannot bill the surgical procedure code even with modifier 53 appended. Instead, if the physician performs and documents a history, an exam, and/or some level of medical decision-making (two of the three), you should bill the appropriate inpatient or outpatient E/M service code.

Example: A patient arrives to pre-op with her blood sugar at 360. This is an unacceptable level for the patient to undergo surgery. An endocrinologist is called to pre-op and starts the patient on an insulin drip, but the patient's blood

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sugar level doesn't drop sufficiently, so the surgeon decides it is in the best interest of the patient to cancel surgery. Although the surgery was canceled due to the well-being of the patient, she was never put under anesthesia, so you should bill an E/M service code based on the physician's documentation.

Check Completion Level for Guidance

Another way to tell if the service needs a 52 or a 53 is to consider if the patient had the entire service the physician intended to provide.

Rule of thumb: Use modifier 53 if the surgeon discontinued the procedure without completing the treatment as planned. Use modifier 52 if the service is complete. Although not foolproof, this method is very consistent in identifying which modifier to use.

When appending either modifier, provide documentation with the claim explaining the reason your physician reduced or terminated the service. Do not reduce your fee. Instead, allow the payor to make a reimbursement decision based on documentation. Documentation should also contain an estimation of the total percent of the procedure that the physician performed and completed.

Bonus: When you bill a discontinued surgery using modifier 53, you can then bill that same surgical code when the actual surgery is accomplished. You cannot do that with modifier 52.

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