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BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Incomplete Service Doesn't Mean Nonexistent Payment

Know the rules for modifiers 52 and 53 to collect your payments despite not completing procedures.

Your surgeon performs a total abdominal hysterectomy, but decides not to do the partial vaginectomy. How should you code for this? The answer: Ask why he stopped the procedure.

When the physician can't complete a procedure, many coders are confused about when to use modifier 52 (Reduced services) and when to use modifier 53 (Discontinued procedure). But once you know why the physician decided not to finish the surgery or service, you can readily pick your modifier.

Avoid this problem: The key to getting reimbursed is to properly code for the services the physician actually performed. You should be sure that the procedures are documented well because the carrier may review them manually. Exactly how much a service was reduced varies with each patient, so some claims-processing systems cannot automatically recognize and process codes appended with modifiers 52 and 53.

Use 52 in Two Situations

Modifier 52 has two functions: to indicate a reduced service or a failed procedure. To use the example above, if a surgeon performs a total abdominal hysterectomy but doesn't do the procedure's vaginectomy portion, then you should report 58200 (Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube[s], with or without removal of ovary[s]) with modifier 52. In this situation, the modifier means that the surgeon elected not to perform a portion of the procedure that the CPT® code definition describes. But that code is still the best one to report.

Modifier 52 also comes in handy when the physician has a failed procedure. For example, the physician is trying to perform a biopsy but can't obtain the biopsy because of a stenosis. Instead, he stops the procedure and reschedules the patient to return for a different type of biopsy at another time.

In this case, you would report the biopsy appended with modifier 52 and include the physician's documentation because it will show the significant work he tried to accomplish during the procedure even though it failed.

Significantly, the doctor did not terminate this service because of risks to the patient's health or well-being, but because of an anatomic problem, so modifier 52, not 53, would apply here.

Modifier 53 Means Stopped or Terminated

When you append a procedure code with modifier 53, you are telling the payer that the doctor could not complete the procedure because the patient's health and well-being are at risk. CPT® defines modifier 53 as a discontinued procedure.

Watch out: You can't use this modifier when the patient elects to cancel the procedure or service. In fact, CMS states that modifier 53 "is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite."