Codify
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Eli's Rehab Report

Modifiers -52 and -53: Asking 1 Question Helps You Pick the Correct Modifier

Experts explain what to do when the physiatrist doesn't complete the procedure

The physiatrist performs an evoked potential nerve stimulation study, but only administers the study unilaterally. How should you code for this? The answer: Ask why he stopped the procedure.

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

Sometimes Neither Modifier Applies

Always properly code for the services the physician actually performed - and this may not always allow you to append modifier -52 or -53. You should be sure that the physiatrist documents the procedures well, because the carrier may review the claims manually. The specific reduction amount of a service varies with each patient.

Some claims-processing systems cannot automatically recognize and process codes appended with modifiers -52 and -53. And CMS requires payers to manually review all claims with these modifiers.

"Many payers require a copy of the report to ensure that a sufficient work effort was expended," says **Cindy C. Parman, CPC, CPC-H, RCC,** president-elect of the AAPC National Advisory Board and co-owner of Coding Strategies Inc. in Atlanta. "This process is more subjective and based on insurance payer guidelines."

Self-defense: Before you use modifier -52, always make sure another code doesn't better describe the procedure the physiatrist performed.

For example, if the physician performs muscle testing on the entire body, excluding the hands, you shouldn't report 95834-52 (Muscle testing, manual [separate procedure] with report; total evaluation of body, including hands). CPT also includes **CPT 95833** (... total evaluation of body, excluding hands), which better describes the service that your physician performed.

Use -52 If Physician Plans Reduced Service

Modifier -52 has two functions: to indicate a reduced service or indicate a failed procedure. For example, if the physiatrist performs a unilateral short-latency somatosensory evoked potential study with peripheral nerve stimulation, he should report 95925-52 (Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs). The modifier tells the payer that the physician elected not to perform a portion of the procedure that the CPT code definition describes (in this case, a test of both limbs).

Example: Aphysiatrist performs a one-extremity electromyogram (EMG) service, and in the middle of the test, the patient tells the physician that she's having a hot flash and insists on stopping the procedure. She says she'll reschedule a few days later to do it again. Should you report this service at all?

Solution: "You should code this circumstance with modifier -52," says **Tiffany I. Schmidt, JD,** director of policy at the American Association of Electrodiag-nostic Medicine. "Modifier -52 usually refers to services that were initiated but stopped because a patient left against medical advice or could not tolerate completion of the test."

Modifier -53 Means Stopped or Terminated

When you append a procedure code with modifier -53, you are telling the payer that the physician could not complete the procedure because he was concerned about the patient's health and well-being, said **Deborah Berry, CPC,** during her presentation, "Modifiers, The Key to Reimbursement," at the American Academy of Professional Coders'2004 national conference in Atlanta.

CPT defines modifier -53 as a stopped or terminated procedure. You can use modifier -53 only if the physician discontinues the procedure after he preps the patient for the service.

Watch out: According to CPT, if a patient elects to cancel the procedure or service "prior to the patient's anesthesia induction and/or surgical preparation in the operating suite," you should not use modifier -53.

Not just for the OR: Some coders think that modifier -53 applies only when your physician performs a procedure in an operating room because of CPT's references to an operating suite. But this is not the case. CPT's definition states that you can use the modifier if the physiatrist has induced anesthesia or performed the operative scrub or prep. You must prep a patient for a procedure in the office or rehab facility just as you would in an operating room.

For instance, the physiatrist sees a patient in the hospital's rehabilitation unit following multiple surgeries resulting from a motor-vehicle accident. The physiatrist notes an infected site on the patient's left leg and decides to perform skin and subcutaneous tissue debridement (11042, Debridement; skin, and subcutaneous tissue). When he is halfway finished debriding the subcutaneous tissue, however, the patient begins to bleed dramatically, and the physician decides to stop the procedure to address the bleeding. In this case, you should report 11042-53.

Modifier -53 is important because it tells the payer that you attempted to perform the entire procedure but could not. This way, if you perform the debridement again a week later, the payer will know that you aren't just submitting a duplicate claim, but that you are trying once again to perform the same procedure.