Modifier Coding Alert

Modifier Mix-ups: Guard Against Modifier 52/53 Confusion With 4 Tips

Reducing fees may be your practice's policy.

When your surgeon discontinues a procedure, you need to decide whether modifier 52 (Reduced services) or modifier 53 (Discontinued procedure) applies, but that decision can be complicated.

By focusing on the following four points you can quickly and correctly make the choice between these two modifiers and ensure your provider gets the reimbursement he deserves.

1. Know Your Modifier 52 Facts

You should use modifier 52 to indicate a partial reduction or discontinuation of procedures and services in other words, when a service is less than the CPT® descriptor or the service is less work than normal. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service.

Example: A physician intends to perform a bilateral tonsillectomy, but only removes one tonsil. Since this code is a bilateral procedure, removing only one tonsil would be a reduced service. In addition, there is no code that describes a unilateral tonsillectomy, explains **Judith Blaszczyk, RN, CPC, ACS-PM**, medical compliance auditor at Auditing for Compliance and Education, Inc. in Overland Park, Kan.

Therefore, you would report this procedure with either 42820 (Tonsillectomy and adenoidectomy; younger than age 12) or 42821 (Tonsillectomy and adenoidectomy; age 12 or over) appended by modifier 52.

2. Identify Risk to Patient Before Using Modifier 53

When your physician decides to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threaten the well-being of the patient, you may need to add modifier 53 to your claim.

Extenuating circumstances around which your physician would discontinue a procedure might be:

- Respiratory distress
- Hypoxia
- Irregular heart rhythm
- Issue related to the anesthesia.

Example: A pain physician begins a left C3-C4 radiofrequency facet denervation procedure with fluoroscopic guidance and has placed the cannula. Before the actual denervation can take place, the patient develops respiratory distress and the procedure must be aborted. In this case, you would report 64633 (Destruction by neurolytic agent, paravertebral facet joint nerve[s], with imaging guidance [fluoroscopy or CT]; cervical or thoracic, single facet joint) with modifier 53 attached, Blaszczyk explains. (You also need to attach modifier LT [Left side] for some payers to indicate the side on which the procedure took place, so your coding would actually be 64633-LT-53.)

Never: "Modifier 53 is not valid for elective cancellations prior to either anesthesia induction and/or surgical preparation in the operating suite or procedure room," continues Blaszczyk.

Remember that the physician coder will use modifier 53. Facility coders would instead use modifiers 73 (Discontinued out-patient hospital/ambulatory surgery center [ASC] procedure prior to the administration of anesthesia) or 74 (Discontinued out-patient hospital/ambulatory surgery center [ASC] procedure after administration of anesthesia). Stay tuned for an article in a future issue about modifiers 73 and 74.

3. Clearly Support the Service That's Provided

If your provider's documentation doesn't include enough detail about the service provided, you may not be able to determine whether modifier 52 or 53 is appropriate or worse, your payer may deny your claim.

Boost: Increase your chances of being paid by making sure your physician thoroughly documents that she started the procedure, and explains why the procedure was either less work than expected or halted. If the procedure was halted unexpectedly, she must include what percentage of the procedure she completed.

"As with any operative report, it is very important that the note clearly supports the service provided," says Blaszczyk. "Poor documentation may put the provider at risk for a general compliance audit."

4. Reducing the Fees Doesn't Necessarily Impact the Claim

Some practices have a policy to reduce their fees when they need to append a CPT® code with either modifier 52 or 53. Some will continue to charge their usual rates. Reducing rates doesn't guarantee your claim will be paid. Payers will make that decision and it would be beneficial to you to know your payers' policies when it comes to modifiers.

"Medicare does direct that the provider should reduce the charge for services reported with the 52 or 53 modifier, based on the percentage of the procedure that was performed," explains Blaszczyk. "Since fees are typically well over the Medicare fee allowance, the reduction of the charge itself would not impact the payment. The payer will reduce the reimbursement based on their opinion as to how much of the procedure was performed, not based on your fee," she adds.