Codify
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Modifier Coding Alert

Multi-Use Modifier: Untangle Modifier 52 and 53 to Bring in Deserved Dollars

Never use modifier 53 when patient elects to stop the procedure.

When your provider stops a procedure, you can use modifier 52 (Reduced services) to seek payment, but you have to be careful not to confuse it with modifier 53 (Discontinued procedure).

Read on to see examples for both situations and cash in for the work your physician performed.

Get the Difference Between Reduced and Failed

You will use modifier 52 "to indicate the service was provided as described by the CPT® code description but not fully," says **Laureen Jandroep, CPC, CPC-H, CPC-I, CPPM, CMSCS, CHCI**, founder and CEO at CodingCertification.org in Oceanville, N.J. "It usually indicates the fee should be reduced."

This modifier has two functions. The first is to indicate a service that was significantly less than usually required to fit the code descriptor.

Example: A patient is having a hysterectomy to accomplish sterilization. The patient has previously had a salpingectomy due to a ruptured ectopic pregnancy, but the code for the sterilization service (58565, Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) specifies bilateral fallopian tube cannulation.

"Since the patient doesn't have bilateral tubes, this procedure can't be billed without modifier 52," says **Brad Hart, MBA, MS, CMPE, CPC, COBGC**, president of Reproductive Medicine Administrative Consulting in West Orange, N.J.

Modifier 52 also comes in handy when a procedure fails.

Example: A patient had a full colonoscopy and during that procedure your physician removes a polyp in the transverse colon. The physician decides that the location of the polyp should be tattooed to allow the surgeon to identify the location. The physician performs a follow-up colonoscopy to tattoo the site to assist the surgeon in identifying the location during a subsequent surgery. The scope could be advanced but there is no need to. "This service would be billed as 45381 (Colonoscopy, flexible; with directed submucosal injection(s), any substance) with modifier 52," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CCC, COBC, CPC-I**, internal audit manager at PeaceHealth in Vancouver, Wash.

Tackle Stopped or Terminated Procedures with 53

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.

Example: Your physician decides to discontinue a puncture to obtain a diagnostic sample of spinal fluid because the patient developed respiratory distress and continuing the procedure could be risky and might endanger the patient's well-being. Use CPT® code 62270 (Spinal puncture, lumbar, diagnostic) with modifier 53 to indicate your physician opted to discontinue the service.

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."

Check Note for Complete Details

No matter what modifier you use for which situation, payers will need to see thorough notes explaining why the service ended.

"In the case of either modifier 52 or 53, the documentation needs to reflect the circumstances that necessitated reducing or discontinuing the procedure," says Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians in Leawood, Kan. "Additionally, in the case of modifier 52, I believe the documentation should reflect the extent to which the service was reduced (how much of the procedure was done and what was left undone)."