Reduced/Discontinued Procedure Modifiers

Occasionally a procedure must be discontinued before it is completed. When this happens, there are modifiers to help to explain to the payer that the service was not completed and whether it is expected to be completed later. The modifiers typically used for in-office procedures are as follows:

Modifier	Short Description	Long Description
52	Reduced Services	Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
53	Discontinued Procedure	Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. *Note:* This modifier 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.

Noridian Instructions

Modifier 52

This modifier is used to indicate partial reduction, cancellation or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. It also identifies a situation where a physician reduces or eliminates a portion of a service or procedure.

Correct Use

- Indicate statement "reduced services" in Item 19 in CMS-1500 claim form (or electronic equivalent)
  - Include brief reason for reduction
  - Documentation includes complete reduction reason retained in patient's record
- Beginning January 1, 2008, contractors apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia
  - Facilities use this modifier to indicate discontinuance of these applicable procedures
  - Continue to use modifiers 73 and 74 for all other types of procedures
- To determine charge amount, reduce normal fee by percentage of service not provided
  - E.g., if 75% of normal service provided, reduce amount billed by 25%
  - Medicare claims processing system reimburses lower of actual charge or fee schedule allowance

Incorrect Use

- Do not confuse with "terminated procedure" modifier 53
- Inappropriate with E/M codes

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Modifier 53

This modifier allows the physician community to state the surgical procedure was discontinued due to extenuating circumstances or a threat to patient well-being.

Correct Use

- Append in first pricing position
- Under certain circumstances, physician may elect to terminate surgical or diagnostic procedure
  - Surgical or diagnostic procedure started and discontinued by physician
  - Prior to or after anesthesia is administered
- Bill Medicare percentage of service completed (see second example below)
  - Medicare Claims Processing System does not automatically reduce payment

Incorrect Use

- Do not use to report elective procedure cancellation, in operating suite, prior to patient's anesthesia induction and/or surgical preparation
- Inappropriate with E/M or anesthesia codes
- Inappropriate to use for Ambulatory Surgery Center (ASC) or hospital facility claims. Use facility modifiers 73 or 74
- Do not confuse with "reduced procedure" modifier 52

Expected or Elected Calls for 52

Modifier 52 applies when the provider *chooses* to cancel a service prior to completion or to provide a reduced service. For example, if the provider plans all along to provide a "lesser" procedure or service, which no other CPT code better describes, modifier 52 applies. Similarly, you would call on modifier 52 if the provider electively cancels a procedure or service prior to completion (this does not apply if the procedure has not been initiated).

Example:

A provider performs a unilateral tonsillectomy for a ten-year-old patient (CPT code 42820). In this case, apply modifier 52. This CPT assumes bilateral surgery, so to show that it was only performed on one side, or *electively reduced*, modifier 52 would be appropriate.

Unexpected or Due to Risk Calls for 53

Modifier 53 applies if the provider quits a procedure because the patient is at risk. For example, the provider does not so much choose to discontinue the procedure, as sound medical practice compels him or her to do so.

Example 1:

A provider attempts to perform Phenol injections to the superior hypogastric plexus; following multiple needle positioning attempts at the right and left L5 region, the procedure is discontinued due to the patient's increased heart rate and suboptimal dye spread.

Example 2:

A provider attempts to place an IUD. However, the physician finds that the patient has cervical stenosis and when the attempt is made it causes pain for the patient. The procedure is discontinued and will be attempted again in 1 month. Document the reason for discontinuation and intent to repeat procedure.

Resources:

https://med.noridianmedicare.com/web/jeb/topics/modifiers/52
https://med.noridianmedicare.com/web/jeb/topics/modifiers/53
https://www.carecloud.com/continuum/52-modifier/
https://www.physicianspractice.com/blog/applying-modifier-52-and-modifier-53
https://www.aapc.com/blog/42008-know-the-difference-between-modifiers-52-and-53/