Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Crack Down on Fee-Reducing Modifier 52 Mistakes

Do you know the CMS rule for partial S&I services?

If you automatically append modifier 52 every time your report suggests a service that doesn't quite meet a CPT code descriptor, you could be cutting your compensation unnecessarily. Here's the rundown on when you should--and should not--append 52 (Reduced services).

Gather Up CPT and CMS Guidance

American Medical Association (AMA) CPT guidelines explain that you use modifier 52 when the physician partially reduces or eliminates a service or procedure at his discretion, says **Stacie L. Buck,** RHIA, CCS-P, LHRM, RCC, vice president of **Southeast Radiology Management** and **FHIMA** president-elect.

The **Centers for Medicare & Medicaid Services** (CMS) guidelines say to use 52 -when a procedure/service performed is significantly less than usually required,- Buck says.

What to do: Report the usual code for the procedure and append 52 to indicate reduced services, Buck says, citing CPT guidelines.

Example: If your patient has had a left mastectomy and presents for a screening mammogram, your payer may want you to report bilateral code 76092 (Screening mammography, bilateral [two-view film study of each breast]) and append 52 to indicate the reduced service, Buck says.

Caution: Different payers may have different coding guidelines for this service.

Get the 52/53 Facts

Modifier 53 (Discontinued procedure) is not interchangeable with 52. You append 53 to a procedure when an unexpected patient response, such as arrhythmia, causes procedure termination, according to CPT Assistant, December 1996, Buck says.

Remember: You use 52 when the physician reduces a procedure at his discretion, not because of a life-threatening situation.

Bottom line: Look for why the physician didn't carry out the full procedure to determine whether you should append 52 or 53, Buck says.

Divvy Up S&I Duties With 52

-Radiological supervision and interpretation- (RS&I) codes require performance of the exact services they describe-- (1) supervision and (2) interpretation.

-Supervision- means personal supervision, including presence, during the radiologic portion of a procedure, according to CMS, Buck says. Important: Personal supervision is a service to a beneficiary--it is not the same as general supervision, which FIs pay hospitals for as physician services, Buck adds, citing CMS.

A different physician may perform interpretation. CMS says that when one physician, such as a cardiologist, reports the supervision portion of the S&I code and a radiologist reports the interpretation, each physician should append 52 to reflect the reduced service, Buck says.

Watch for: These are CMS- rules. Other payers may not recognize 52, Buck says. Check each payer's guidelines to be sure.

Don't Jump the Gun on 52

Knowing when not to use a fee-reducing modifier can be almost as important as knowing when to use it. Two scenarios below show that you should do your research before appending 52.

Scenario 1: A patient undergoes a CT without contrast, and the radiologist focuses his report on the sinuses. You believe the correct code is 70486 (Computed tomography, maxillofacial area; without contrast material). Should you append 52 because the radiologist does not describe the full area in detail?

Solution: No need for 52 here, says **Sandi Scott, CPC, PMCC** instructor and director of audit and training for **InSight Health Corp**. in Lake Forest, Calif.

According to the American College of Radiology, you don't have to code CTs by the slice, she says. Code 70486 should be appropriate on its own.

Watch out: The ACR says that 70486 is bilateral by definition. If for some reason the physician did not perform the expected bilateral study, and your payer defines 70486 as bilateral, you should append 52.

Scenario 2: You receive a report with the title -Complete x-ray of the knee.- The documentation clearly states that the radiologist performed a three-view exam. Should you report 73564 (Radiologic examination, knee; complete, four or more views) and append 52 to indicate the reduced service?

Solution: No. You should always check your CPT manual to discern if you have a more appropriate choice before you append 52, says **Catherine Brink**, CMM, CPC, president of **Healthcare Resource Management** Inc. in Spring Lake, N.J. This is especially important for x-ray codes, which are often defined by the number of views, she adds.

Because you should base your coding on the body of the report (which explains what actually happened) rather than the title, you should see if you have a code for three views of the knee.

Your best option is 73562 (- three views).

Act Early to Prevent Payment Problems

Smart: Send in documentation with a cover letter that illustrates the reduced procedure to prevent payment delays, says **Laureen Jandroep,** OTR, CPC, CCS-P, CPC-H, CCS, CPC-EMS, **CodeRyte Inc.** coding analyst and coding review teacher.

Your cover letter should include an approximation of how much of the procedure you performed (such as 80 percent) to help the claims reviewer determine the value of your services. Your claims reviewer may not be an expert in your specialty, so use plain language to clearly show the work that deserves payment.

Tip: With a modifier like 52, which reduces compensation, don't submit a lower-than-usual fee. Leave that up to the carrier. Submitting a reduced fee could cause the payer to slash your already-diminished compensation, Jandroep says.