Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Reduce Your 'Reduced Services' Coding Headaches

Boost your bottom line by knowing when not to apply modifier 52

Every time you consider appending modifier 52 (Reduced services) to your claim, you know you could be shrinking your reimbursement. Avoid unnecessary pay cuts by applying the lessons learned in our five examples below.

Master Modifier 52

Rule: You should append modifier 52 to codes for procedures that accomplish some result, but don't fully complete the requirements of the procedure's description, says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, senior instructor and director with the **CRN Institute** in Egg Harbor, NJ.

Smart: Send in documentation with a cover letter that illustrates the reduced procedure to prevent payment delays, says Jandroep.

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 ...quot; leave that up to the carrier. Submit-ting a reduced fee could cause the payor to slash your already diminished compensation, Jandroep warns.

Remember: Don't confuse modifier 52 with 53 (Discontinued procedure). Use 53 when the physician stops the procedure because continuing would put the patient's health in danger, says **Catherine Brink, CMM, CPC**, president of **Healthcare Resource Management Inc**. in Spring Lake, NJ.

You may also distinguish the two by this general rule--if the patient received some benefit from the procedure, 52 may be more appropriate. If you don't perform enough of the procedure for the patient to receive any benefit, you'll probably append modifier 53, advises Jandroep.

Apply Your Modifier 52 Know-How

Now that you know the basics, see if you can correctly identify when to append 52 in these scenarios.

Interpret Extra X-Ray View

Scenario: 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, advises Brink. 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).

Heed Health As Grounds For Halting

Scenario: Your gastroenterologist performs a diagnostic upper gastrointestinal endoscopy (EGD). He encounters an obstruction while inserting the endoscope. After several unsuccessful attempts at insertion, he decides it's in the patient's best interest to stop the procedure. Does this count as a reduced procedure?

Solution: You should not use 52 for this procedure. Instead report 43235 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]) and append 53 because the physician stopped out of concern for the patient's well being. Explain the encounter accurately, giving the carrier the exact reasons the physician stopped the procedure.

You're unlikely to use 52 with an endoscopy, but if the physician begins a diagnostic EGD and decides not to scope the entire tract for reasons unrelated to the patient's health, you should append the reduced services modifier.

Audiology Has Rules For 52

Scenario: Your report reveals comprehensive audiometry on a patient who is deaf in his right ear. The provider indicates that he only performed the audiometry on the patient's left ear. You determine you should report 92557 (Comprehensive audiometry threshold evaluation and speech recognition [92553 and 92556 combined]). Does this claim need a modifier 52?

Solution: Yes. Audiology exams offer a great example of using 52 to demonstrate that you didn't perform a full bilateral procedure, says Brink.

Your CPT manual tells you the CPT codes in the "Audiologic Function Tests With Medical Diagnostic Evaluation" section are bilateral. Translation: Each of these codes represents testing both ears. If you report 92557, you're telling the payor that you performed comprehensive audiometry on the left and right ears. If you perform the study on only one ear, append 52, instructs the manual.

See to CT Slice Specifics

Scenario: 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 doesn't 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, CA.

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

The ACR also says that 70486 is bilateral by definition. As in the audiology example above, if for some reason the physician did not perform the expected bilateral study, you should append 52.

Ponder 52 For Partial Craniectomy

Scenario: Your surgeon removed a basal cell carcinoma that extended below the skin to the skull. Result: He had to perform a partial excision of the outer table of the skull. Does this partial excision merit a 52?

Solution: Yes. The appropriate code is 61500 (Craniectomy; with excision of tumor or other bone lesion of skull). Snag:

The craniectomy code assumes a full-thickness procedure. You should append 52 to tell the payor the surgeon only performed a portion of the described procedure.

Abide By Medicare's Modifier And E/M Rules

Scenario: Your physician performs a comprehensive history and physical exam--including a pelvic exam, a clinical breast exam and a Pap smear--on a 70-year-old established patient. You use codes G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) for Medicare coverage of these services. Can you also report a preventive E/M for this visit? If so, should you append 52 to reflect Medicare's payment for the screening exams?

Solution: In general terms, the answer is yes to both, but you need to check with your carrier for the details.

You should report G0101 and Q0091 to your carrier. You may also report the preventive E/M with 99397 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization[s], laboratory/diagnostic procedures; 65 years and over) and append 52, advises Atlanta healthcare consultant and PMCC instructor **Susan Pincus, CPC, CHC.**

Medicare doesn't allow you to append 52 to E/M services, but in this case your carrier will likely deny 99397 whether or not you append the modifier. Once you get the denial, you may bill the reduced fee to the patient or secondary payer if it covers preventive services, Pincus says.

Tip: Check with your local carrier to be sure it wants you to report the preventive service to it at all or if you should simply charge the patient or secondary payer, she notes.

Lesson: Don't automatically append modifier 52 every time your report suggests a service that doesn't quite meet the CPT descriptor. Check for why the physician shortened the procedure and keep track of guidance telling you what services Medicare believes each code represents.