Codify
BY AAPC

Outpatient Facility Coding Alert

Yes, You Can Report Modifier 52 in An ASC Sometimes

Modifier 52 (Reduced services) is primarily designed for physician use, but ASCs can report modifier 52 on certain claims or in certain circumstances. Check our list of factors to consider when deciding whether to submit modifier 52 on outpatient facility claims.

Know the Modifier Basics

- Coders report modifier 52 when the physician performs a service that is less than the CPT® code descriptor or when the procedure required significantly less work than the code's descriptor would indicate as normal.
- ASCs should use modifier 52 to indicate discontinuance of a radiology procedure or other procedures that do not require anesthesia.

Watch the Timing

- Do not use modifier 52 for discontinued or terminated procedures that involve the use of anesthesia. Instead, verify whether modifiers 53, 73, or 74 might be appropriate. You should also steer clear of modifier 52 if the procedure is cancelled before the patient is prepped and wheeled into the procedure room, or when the procedure is electively cancelled.
- If a procedure is cancelled after anesthesia administration, you won't need modifier 52. Instead, physicians should report modifier 53 (Discontinued procedure) and hospital outpatient and ASC facilities should report modifier 74 (Discontinued outpatient hospital/ambulatory surgical center [ASC] procedure after the administration of anesthesia).

Prepare for Modifier 52 Payment

- Appending modifier 52 to a claim may - or may not - affect payment, depending on the payer.
- ASC surgical procedures billed with modifier 52 should not be subjected to further pricing reductions. In other words, the multiple procedure price reduction rules do not apply for modifier 52 claims in ASCs.
- Medicare contractors apply a 50 percent payment reduction to procedures reported with modifier 52.
- Commercial payers might also require or utilize modifier 52 in an outpatient setting. Keep a reference list for your facility showing each payer's modifier 52 stipulations and fee schedules. Be aware that some claims scrubbers drop the modifier in processing so while the intent is there to alert the payer of the reduced service, it may not always be conveyed.
- When you report modifier 52, some payers want the ASC to include test results, operative notes, or hospital records to substantiate the reason for reporting a reduced service. If you don't submit this additional paperwork, your claim might be denied.

ASC example: A patient presents for radiologic examination to visualize the pharynx (the passage for food and air) and larynx (the organ of voice). The physician attempts the fluoroscopy procedure multiple times but is unsuccessful. You should report 70370 (Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique) with modifier 52.

Explanation: A key element of this code indicates that the procedure includes x-ray fluoroscopy and/or magnification

technique in addition to the radiologic exam. The physician was unable to perform all elements of the procedure, so appending 52 modifier is appropriate.