Modifier Coding Alert

Outpatient Procedure: Uncover ASC's Use of 52 with Radiology Procedures

Ignoring modifier 52 can cost your ASC thousands over time.

You'll find that Medicare's instructions on modifier 52 use for facilities claims, such as with an ambulatory surgical center (ASC), is very different than the instructions for physician claims. Furthermore, commercial payers have varying modifier 52 policies.

Continue reading to learn more about how to use modifier 52 with ASC claims versus physician claims in order to submit accurate, reimbursable claims.

Realize CMS Requires 52 with Radiology Services

Physicians tell their payers when they perform services that are less than the code descriptor by using modifier 52 (Reduced services). However, ASC coders use modifier 52 a bit differently when dealing with CMS.

"Ambulatory surgical centers and hospital outpatient facilities are instructed by their Medicare payers to use modifier 52 only with radiology procedures, or any other procedure that doesn't include anesthesia, when the procedure performed is less than the code description," says **Joanne Schade-Boyce, MS, BSDH, CPC, ACS**, revenue cycle auditor & ICD-10 trainer at CodeMed Solutions, LLC in Germantown, Md.

Aside: For other services physicians discontinue prior to or after anesthesia is administered, outpatient hospital facilities and ASCs need to use modifiers 73 (Discontinued out-patient hospital/ambulatory surgery center [ASC] procedure prior to the administration of anesthesia) or 74 (... after administration of anesthesia).

Calculate the Facility Reduced Service

Medicare and commercial payers that follow CMS guidelines will require that you attach modifier 52 to reduced facility radiology procedures where anesthesia isn't included.

Example: A patient presents to the ASC for a radiologic examination to visualize the pharynx. During the course of the procedure, the physician attempts the fluoroscopy procedure multiple times but is unsuccessful.

Code it: You would code the procedure using 70370 (Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique) with modifier 52 attached because the procedure code includes x-ray fluoroscopy and/or magnification technique with the radiologic exam, and the physician couldn't complete fluoroscopy portion of the service. "The modifier provides the communication to the payer that the service was not completed to the full code description," Schade-Boyce explains.

Calculate it: ASCs use a set fee schedule, the hospital outpatient prospective payment system (OPPS), and that schedule assigns a payment indicator of Z3 (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs) to 70370. The 2015 OPPS proposed payment amount is $63.73.

The Z3 indicator means that the payer may reimburse you for a radiology service separately when it's integral to a surgical procedure on the ASC list. The radiology payment is based on MPFS non-facility practice expense RVUs.

Note: Medicare always pays 50 percent for these procedures but they encourage each facility to contact their

commercial payers to determine what documentation they require for reimbursement. The Medicare total charge for the previous example is therefore $63.73 x 0.5 = $31.87.

Beware: Commercial payers' policies that have to do with modifier 52 fluctuate. Some follow CMS guidelines and some may not require the modifier for only radiology and other procedures that don't include anesthesia. Still others may not want to see modifier 52 attached to procedure codes on any facility claims. Communicate with your payers to learn their coding preferences and to create a payer matrix .