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Railroad Medicare

CPT Modifier 52

Description:
Reduced services

Guidelines/Instructions:

- This modifier may not be submitted with evaluation and management (E/M) procedures
- For procedures that are terminated prior to completion and that are submitted by an ASC, refer to CPT modifiers 73 and 74
- For procedures that are terminated prior to completion and that are submitted by a physician and performed in an ASC, refer to CPT modifier 53
- Documentation required with the claim:
    - A concise statement that explains the nature of the reduced service along with any other supporting documentation that the provider deems relevant
    - The concise statement may appear on the operative report, but it must be clearly identified. You may circle, underline, highlight or write the concise statement on the operative report. Failure to submit the appropriate information will result in a denial of the claim.
    - This statement may be entered in the electronic documentation field or submitted via the fax attachment process. For paper claims, this documentation must be submitted as an attachment to the CMS-1500 claim form.
    - Services that are submitted with CPT modifier 52 that do not include a concise statement will be rejected as 'unprocessable' and must be resubmitted as new claims
- Special Note for **Ophthalmology**: Reimbursement for CPT code 92136 includes one professional component (CPT modifier 26) and two technical components (HCPCS modifier TC)
    - If this procedure is performed with a unilateral technical component, submit the technical component with CPT code 92136, HCPCS modifier TC and CPT modifier 52. It is not necessary to submit a concise statement about the use of CPT modifier 52 in this instance. Palmetto GBA will assume that the modifier indicates a unilateral technical component.
    - If this procedure is performed with a unilateral technical and professional component, submit the service with CPT code 92136 and CPT modifier 52. It is not necessary to submit a concise statement about the use of CPT modifier 52 in this instance. Palmetto GBA will assume that the modifier indicates a unilateral technical component.
- Special Note for **Ambulatory Surgical Centers** (ASCs): Effective for dates of service on or after January 1, 2008, report this modifier for discontinued radiology procedures and other procedures that do not require anesthesia. Other multiple procedure price reductions will not apply when this modifier is submitted by ASCs. Refer to CPT modifiers 73 and 74 for other discontinued procedures.
- Special Note for **Radiology**:
    - This modifier may be submitted with radiology services in which the 'supervision' and 'interpretation' components are performed by different providers. The services should be submitted with CPT modifier 26 followed by CPT modifier 52. Note that these instructions do not apply if one provider has already submitted a claim and been reimbursed for both the 'supervision' and 'interpretation' component.
    - Services for which the billed code represents 'bilateral' when performed 'unilaterally' or when the available code describes more than was captured on the film may be submitted with CPT modifier 52. In the electronic documentation record use a short description of why the service is submitted as a reduced service, such as 'unilateral service.'

Reference:

- Ambulatory Surgical Centers: CMS Pub. 100-04, Chapter 14, Section 40.4 (PDF, 293 KB)
- CMS Pub. 100-04, Chapter 13, Section 80.1 (PDF, 367 KB)
- CMS Pub. 100-04, Chapter 12, Sections 20.4.6, 30.6.1, 40.2 #10, and 40.4 (PDF, 1.44 MB)

last updated on 02/27/2012
ver 1.1.1