Pain Management Coding Alert

Reader Question: Get Your Documentation in Order for Modifier 52 Claims

Question: We recently submitted a claim for reduced services because the physician had to stop a procedure in order to ensure patient safety. The insurer denied the claim due to "insufficient documentation." What types of documentation should we file for these claims?

Kentucky Subscriber

Answer: While the dreaded insufficient documentation denial is one of the most common when coding with modifier 52 (Reduced services), the exact type of notes you need to include depends on the why the provider didn't finish the service.

Background: According to CGS Medicare, the Medicare contractor in your state, you should use modifier 52 when:

- Using a code that is indicated as a bilateral procedure, but performed unilaterally (and no unilateral code exists); or
- Coding for "surgical procedures that are incomplete based on the physician's medical judgment and decision-making."

Documentation: When submitting a modifier 52 code, CGS recommends that you:

- "Submit the reason for the reduced service in the electronic documentation field (or, if you are approved to submit paper claims, in Item 19)";
- Double-check your modifier choice, as modifier 52 might not be the best choice. "If a procedure is a failed operative procedure or a reduced operative procedure after induction of anesthesia and after the start of the operative procedure, there are more appropriate modifiers to indicate canceled or discontinued procedures," CGS states;
- Include a concise statement about how the service differs from the usual; and
- Make a copy of the operative report and include it with the claim.

Read more: See the rest of the CGS guidance on modifier 52 for yourself at www.cgsmedicare.com/parta/pubs/news/2014/0814/cope26558.html.