

S & I and -52 MODIFIER CODES

Information placed on some web sites concerning the S & I code and -52 modifier code is erroneous and misleading. Research of web sites for CMS, the Medicare Claims Processing Manual, the AMA CPT 2007 Professional Edition and the MLN Matters reveal when and how these codes are to be used. The inference to radiology groups is that if a RPA does a procedure, then one or both of these codes apply.

According to the Medicare Claims Processing Manual, Chapter 13, 80.1, page 37, the regulation for the S & I (Supervision & Interpretation) code states this code is

“used to describe the personal supervision of the performance of the radiologic portion of a procedure by one or more *physicians* and the interpretation of findings. In order to bill for the supervision aspect of the procedure , the *physician* must be present during its performance....The interpretation of the procedure may be performed later by another *physician*. In situations in which a cardiologist, for example, bills for the supervision (the “S”) of the S&I code and a radiologist bills for the interpretation (the “I”) of the code, both physicians should use the -52 modifier indicating a reduced service...”¹

The S & I code pertains to *physicians*, and not to non-physician personnel, such as RPAs, and should not be applied to situations using RPAs. The hospital policies govern the utilization and parameters of practice of the RPA through the credentialing process. Within IDTFs, the code-specific supervision guidelines apply.

In the CMS Change Request (CR) 4250 and Related Transmittal (CR) 804 define the usage of the -52 modifier as

“The -52 modifier is used to indicate that a service that did not require anesthesia was partially reduced *or* discontinued at the physician’s discretion. ...The modifier is reported most often to identify interrupted or reduced radiological or imaging procedures...”²

The -52 modifier code indicates a procedure that was reduced or eliminated for a variety of reasons, and is at the physician’s discretion to make this call. Since some service was technically provided, even though the result was inadequate to make a diagnostic statement, it is correct to use the -52 modifier code for the *physician’s* service.³

The other situation that the -52 modifier code can be used is when two physicians or providers participate in a procedure, the fee is divided by utilizing the -52 modifier code. Note that the regulations state the individuals must be *providers*, meaning that CMS recognizes them as having provider numbers for reimbursement. RPAs are not considered providers, therefore the -52 modifier code can NOT be applied to functions of the RPA.¹

REFERENCES

1. Medicare Claims Processing Manual, Chapter 13, 80.1, Physician Presence, page 37.
2. Medicare Learning Network, MLN Matters, MM4250, “*Modifier -52*” January, 2006 Related CR Transmittal #804.
3. American Medical Association CPT 2007 Professional Edition, page 440.