PI Payment Policy 60 Reduced Services and Discontinued Procedures Reimbursement Policy, Professional and Facility

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Policy

This reimbursement policy applies to all health care services billed on UB04 forms (CMS 1450) and to those billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design, and other factors are considered in developing reimbursement policy.

Overview

As defined in the Current Procedural Terminology (CPT®) book, under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of Modifier 52 (Reduced Services), signifying that the service is reduced. This provides a means of reporting Reduced Services without disturbing the identification of the basic service. Modifier 52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia. It is not appropriate to use Modifier 52 if a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.

Reduced Services

There are no industry standards for reimbursement of claims billed with Modifier 52 from the Centers for Medicare and Medicaid Services (CMS) or other professional organizations. Molina Healthcare standard for reimbursement of Modifier 52 is 50% of the Allowable Amount for the unmodified procedure. This modifier is not used to report the elective cancellation of a procedure before anesthesia induction, intravenous (IV) conscious sedation, and/or surgical preparation in the operating suite. Modifier 52 should not be used with an evaluation and management (E/M) service.

Discontinued Procedures

The term "Discontinued Procedure" designates a surgical or diagnostic procedure provided by a physician or other health care professional that was less than usually required for the procedure as defined in the Current Procedural Terminology (CPT®) book

Professional Claims:

Discontinued Procedures are reported by appending Modifier 53 (Discontinued Procedure). Modifier 53: indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. It is not appropriate to use Modifier 53 if a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.

There are no industry standards for reimbursement of claims billed with Modifier 53 from the Centers for Medicare and Medicaid Services (CMS) or other professional organizations. Molina Healthcare standard for reimbursement of Modifier 53 is 50% of the Allowable Amount for the unmodified procedure. Note: Modifier 53 is not applicable for facility billing and is not valid when billed with E&M (Evaluation & Management) or time-based codes.

Facility Claims:

Discontinued Procedures in a facility setting are reported by appending either Modifier 73 or Modifier 74. If the procedure was discontinued prior to the administration of anesthesia, Modifier 73 should be appended and will be reimbursed at 50% of the Allowable Amount for the unmodified procedure. If the procedure was discontinued after the administration of anesthesia, Modifier 74 should be appended and will be reimbursed at 100% of the Allowable Amount for the unmodified procedure. Note: Modifiers 73 and 74 are only used to indicate Discontinued Procedures for which anesthesia is planned or provided and are not applicable in a professional setting.

Supplemental Information

Modifier Codes	
52	Reduced Services
53	Discontinued Procedure
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Definitions

Term	Definition
CMS	Center for Medicare and Medicaid
Allowable Amount	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For the percentage of charge or discount contracts, the Allowable Amount is determined as the amount billed, less the discount.
Discontinued Procedure	Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding Modifier 53 to the code reported by the individual for the discontinued procedure. For facility claims, discontinued procedures may be reported by appending Modifier 73 or Modifier 74.
Reduced Services	Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

References

This policy was developed using

- CMS
- State Medicaid
- State Contracts