PROVIDER REIMBURSEMENT GUIDANCE			
Reduced Services and Discontinued Procedures			
Original Date Approved	Effective Date Senior Care Options/One Care	Effective Date Medicare Advantage*	Revision Date
04/08/2022	08/01/2022	08/01/2022	

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ Medicare Preferred – (PPO) MA*
☒ Medicare Value - (PPO) MA*
☒ Medicare Preferred – (PPO) RI*
☒ Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

According to the American Medical Association (AMA), certain circumstances require a service or procedure to be partially reduced or eliminated at the physician's discretion. CCA will reimburse such circumstances as defined in the Current Procedural Terminology (CPT®) book. In this situation, the service or procedure provided can be reported by its usual procedure number and the addition of Modifier 52 Reduced Services, which signifies the service was reduced and does not disturb the identification of the basic service.

Modifier 52 should be applied to services or procedures which represent diagnostic or surgical services that were reduced.

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.

CCA recognizes Modifier 53 when appended to a service to indicate that a surgical or diagnostic medical procedure was either terminated or was started after induction of anesthesia but discontinued due to extenuating circumstances beyond the control of the physician, the other qualified healthcare professional or the patient.

REIMBURSEMENT REQUIREMENTS:

Reduced Services

CCA will reimburse services billed with a Modifier 52 at 50% of the allowed amount for the unmodified procedure.

- Modifier 52 should not be 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.
- Modifier 52 should only be reported with one procedure code.

REIMBURSEMENT REQUIREMENTS: (cont.)

Discontinued Procedures

A discontinued procedure indicates 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 and are reported by appending Modifier 53.

- 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.
- The CCA standard for reimbursement of Modifier 53 is 25% of the Allowable Amount for the unmodified procedure.
- Modifier 53 is not applicable for facility billing and is not valid when billed with E&M or time-based codes.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

- American Medical Association (AMA) Current Procedural Terminology (CPT®)
- cms.gov
- CMS Medicare Claims Processing Manual - Chapter 04 - Part B Hospital (Including Inpatient Hospital Part B and OPPS): Section 20.6.4, 20.6.6
- CMS Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Section 20.4.6, 30.1, 30.6.1, 40.2, 40.4A
- CMS Medicare Claims Processing Manual - Chapter 13 - Radiology Services and Other Diagnostic Procedures: Section 80.1
- CMS Medicare Claims Processing Manual - Chapter 23 - Fee Schedule Administration and Coding Requirements: Addendum
- Commonwealth Care Alliance

POLICY TIMELINE DETAILS

1. Effective 08/01/2022