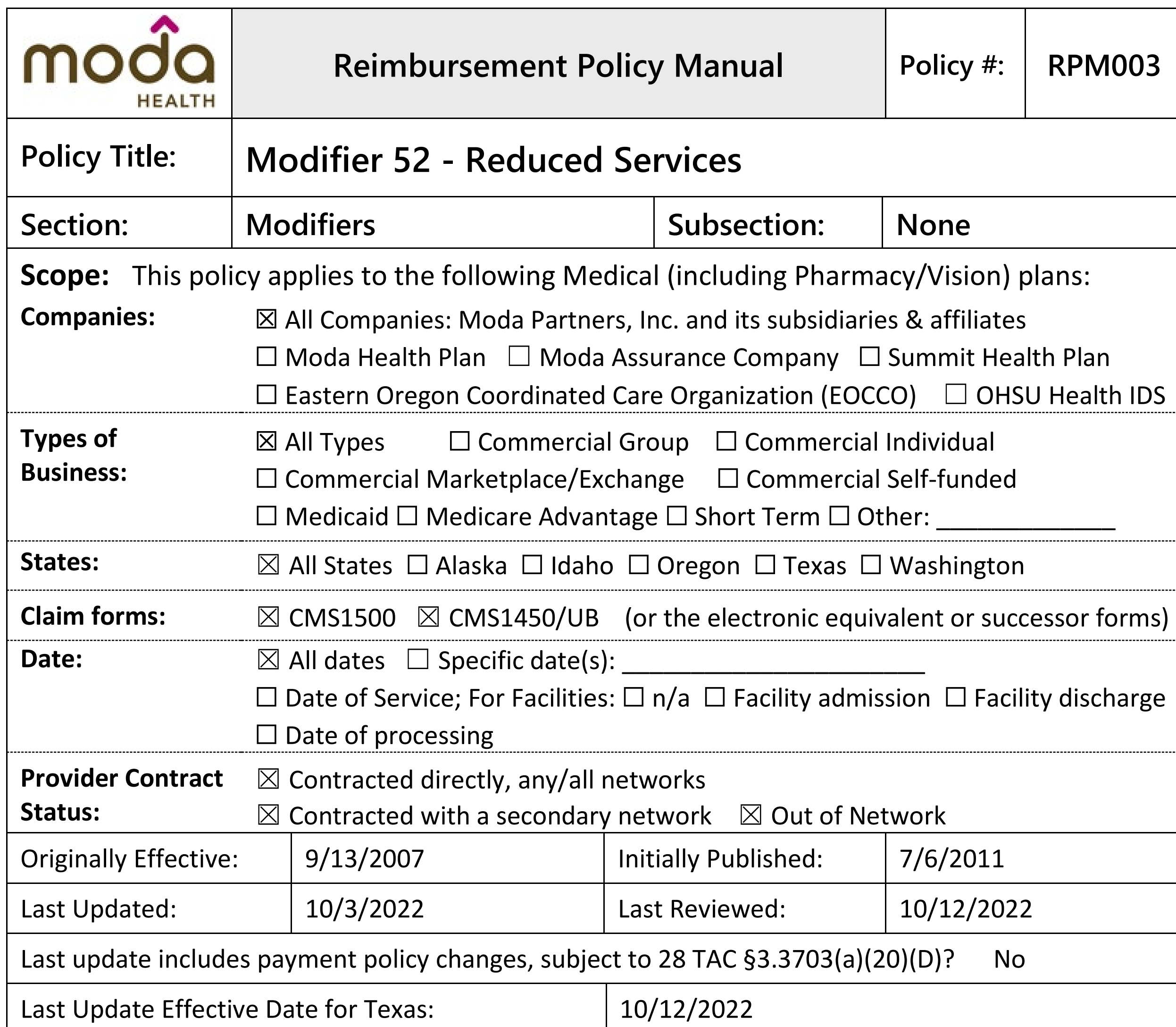

moda HEALTH	Reimbursement Policy Manual		Policy #:	RPM003
Policy Title:	**Modifier 52 - Reduced Services**			
Section:	**Modifiers**	**Subsection:**	**None**	

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: ____________
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): ______________________ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	9/13/2007	Initially Published:	7/6/2011
Last Updated:	10/3/2022	Last Reviewed:	10/12/2022
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?	No		
Last Update Effective Date for Texas:	10/12/2022		

Reimbursement Guidelines

A. General

1. Claims for reduced services are manually priced. The allowance is adjusted based on the percentage of the full service that has been performed and documented.
2. Modifier 52 is used only to report a service that has been reduced when no other code exists to report what has been done (the amount of the procedure that was completed).

B. Requirements When Modifier 52 is Billed

When modifier 52 is submitted, the claim must be accompanied by both a statement explaining what percentage and portion of the service was not completed and the operative report or records documenting the service. If the statement explaining the nature and amount of the service reduction and the medical records for the reduced service did not accompany the claim, this information will need to be requested in most cases, resulting in further delay of the claim.

C. Comparison Radiology Studies

When repeat radiology films are performed and interpreted only as a comparison study to the previous and/or most recent films, some radiologists will submit the professional component with a

modifier 52 appended to indicate a comparison study. The radiology report will also document a comparison study or comparison film. In these cases, the line item with modifier 52 will not be denied for an invalid modifier combination. Please include a notation “comparison study” on the claim in box 19 or on the line item comments of the electronic claim. Records will not be requested for manual review.

1. Reimbursement is made at 70% of the usual fee for a full radiology reading.
2. This determination was made based on correspondence from multiple radiology providers submitting comparison studies in this manner.

D. Denials for Modifier -52 Invalid for Procedure Code

When modifier 52 is billed inappropriately in one of the invalid combinations listed below, the line item will be denied as an invalid code-modifier combination.

Denial explanation codes include:

Code	Explanation Code Description
514	The modifier that was billed is invalid for the procedure.
u13	The modifier used is inconsistent with the procedure code.
u39	Per NPFS PC/TC indicator, this procedure code is a service covered incident to a physician's service and modifier is not appropriate.

835 CARC/RARC denial combination:

	Code	CARC/RARC Description
CARC:	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
RARC:	None used	n/a

E. Invalid Procedure Code Combinations for Modifier -52

Modifier -52 is not considered valid when used with:

1. All-or-nothing procedure codes
    a. Examples:
        i. 72020 XR spine, single view
        ii. 97010 – 97028 PT modalities, one or more areas, non-timed codes.
    b. Exception: When repeat radiology films are performed and interpreted only as a comparison study to the previous and/or most recent films.
2. Codes in a series where a lesser code is available
        i. For example: instead of 90806-52 use 90804.
        ii. Exception: When repeat radiology films are performed and interpreted only as a comparison study to the previous and/or most recent films. (e.g. 71045, 71046, 73090)
3. Codes with descriptions specifying “unilateral or bilateral”

4. Codes with descriptions specifying “up to,” “at least,” “any number of,” or similar phrases. For example:
    a. 11900 “…up to and including 7 lesions”
    b. 12001 “…2.5 cm or less”
    c. 96913 “…requiring at least 4-8 hours of care under direct supervision of the physician…”
    d. 11719 “…any number”
5. Unlisted procedure codes
6. Evaluation and management (E/M) codes other than Preventive Medicine Service codes.
    a. Select the code that best describes the level of service performed. If services documented do not meet the criteria for the lowest level of E/M available, then service either is not reportable, or an unlisted code must be used.
    b. For Preventive Medicine E/M codes modifier 52 will be considered valid to report an annual women’s exam when other systems usually included in an age-appropriate preventive exam are not addressed.

F. Other Incorrect Uses of Modifier -52

1. Another modifier is available to describe the reduced service.

    Example:

    Code 74246-26-52 is billed with notation on claim “interpretation only.” Use of modifier 52 is not appropriate; modifier 26 already describes “interpretation only.”

2. Another code is available to describe the reduced service.

    Example:

    Precipitous Delivery. (Moda [B])
    59400-52, 59409-52, or 59410-52 may not be reported. This is an incorrect use of modifier 22.
    If the provider arrives in time to deliver the placenta, CPT code 59414 (*Delivery of placenta, separate procedure*) may be reported. The antepartum care only, and postpartum care only procedure codes may also be reported as appropriate.

3. Multiple attempts were required to successfully accomplish the procedure.
    a. All attempts to accomplish a procedure during the same patient encounter or operative session are included in the procedure code for the successful procedure. (CMS[12])
    b. Examples (not all inclusive):
        i. IUD placement.
            1) Procedure note describes: The first two IUDs were placed without difficulty but failed to deploy and were expelled or removed. A different lot number and different size IUD was selected, and the third IUD was placed and deployed normally without issue.

2) Claim submitted:

Codes & Units submitted	Comments
58300 x 1 unit	Successful IUD placement. Reimbursement for this line includes all attempts required in this session for a successful IUD placement.
J7301 x 1 unit	Supply for successfully placed IUD.
58300-52 x 2 units	Incorrect use of modifier 52. Reimbursement for unsuccessful attempts is included in the allowance for the successful procedure.
J7301-52 x 2 units	Incorrect use of modifier 52. 1) Modifier 52 may not be used for supply items. 2) Defective implants or supplies are to be returned to the supplier for replacement or refund. 3) Related note (not included in this example): Dropped or contaminated implants or supplies may not be reported on the claim. These are a practice expense or cost of doing business and are not eligible for reimbursement.

ii. Placement of esophageal stent (e.g., 43212).

iii. Placement of biliary duct or pancreatic duct stent (e.g., 43274-43276).

iv. Placement of ureteral stent (e.g., 50605, 50693-50695, 50947, 51045, etc.).

v. Placement of intracoronary stent(s) (e.g., 92928-92944).

G. Reduced Services of Time-Based Codes

i. For any time-based procedure codes (codes with descriptions that specify an increment of time such as minutes or hours) the duration of the service must be clearly documented in the medical record. Documentation in terms of "units" does not constitute documentation of time or duration. The actual number of minutes or begin-to-end times must be used.

ii. Only one time-based code may be performed at a time. If three units of "each 15 minutes" codes are billed, the total duration of the visit must be a minimum of 45 minutes, with additional time expected if evaluation and management, radiology, or supervised modalities are also billed. If more than one procedure code is billed for the same date of service, then in order to fully support all of the billed services the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.

iii. Methods and examples for time documentation:

a. Acceptable:

i. Specific number of minutes. Example: "Manual therapy to lumbar spine x 15 minutes."

ii. Listing begin-time and end-time for service. Example: “E-stim to cervical neck, 09:30 – 09:45.”

b. Unacceptable:

i. Documenting time in terms of “units”. Examples: “One unit of pulsed ultrasound was administered.” or “Ther Ex 1 unit.”

ii. Documenting time using a range. Example: “Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms.”

iii. Documenting a quantity but not specifying the measurement or increment used. Example: “97110 Exercises x 2.”

iv. No time mentioned at all. Example: Checking or circling “NMR” or “TE” with no additional information documented.

iv. When the duration of a reduced time-based procedure is not documented in the record:

a. When a time-based procedure code is billed with modifier -52 attached, if the time/duration is not documented in the medical record, then the documentation is incomplete.

b. The service is not fully supported in the record, and the reduced service is not eligible for separate reimbursement.

c. The reduced service will be denied with an explanation code stipulating that the service was not documented (due to the incomplete documentation).

v. When the duration of a reduced time-based procedure is documented in the record:

a. Time must be reported in full one-minute increments. Any fractions of less than one-minute will not be considered in the review.

b. If the time is documented with a range of time, only the lowest amount of time is considered to be supported in the record. Example: “Total time for performing exercises is 5 – 8 minutes.” Only five (5) minutes is supported by this documentation.

c. If the amount of time the service was performed is less than 50% of the time described for the procedure code, then the service will not be separately reimbursable, but will be considered incidental to the other services performed on that date.

d. If the amount of time the service was performed is 50% or more of the time described in the procedure code definition, the service will be reimbursed at the full rate.

i. For 15-minute PT modalities, this policy effectively mirrors the CMS "8-minute rule."9 For services of eight to 14 minutes, round up to the next unit.

1) 0 - 7 minutes (& 7.5 minutes) – not separately reimbursable

2) 8 – 22 minutes – 1 unit

3) 23 – 37 minutes – 2 units

4) 38 – 52 minutes – 3 units

5) etc.

ii. For procedure codes stipulating “each 30 minutes,” at least 15 minutes of the service must be performed and clearly documented to be separately reimbursable.

iii. For procedure codes stipulating “each hour” or “each additional hour,” at least 30 minutes of the service must be performed and clearly documented to be separately reimbursable.

H. Use of Modifier 52 for ASC or Outpatient Hospital Facility Fees

1. Modifiers 73 and 74 are used to report terminated or discontinued services in the Ambulatory Surgery Center (ASC) or outpatient hospital setting.
    a. However, the use of modifiers 73 and 74 are limited to procedures for which anesthesia is planned.
    b. When anesthesia is not planned, modifier 52 is used instead when the procedure is terminated, discontinued, or otherwise reduced in an ASC or outpatient hospital.
2. Procedures reported by ASCs or outpatient hospitals with modifier 52 appended will be reimbursed at 50% of the usual applicable fee schedule rate for the facility fee.
3. For full details, see “Modifiers 73 & 74 - Discontinued Procedures For Facilities.” Moda Health Reimbursement Policy Manual, RPM049.

I. Selecting Between Modifier 52 and Modifier 53

1. Use modifier 52 when:
    a. The service was reduced at the physician’s discretion.
    b. The service was reduced because a portion of the relevant anatomy is absent (either congenitally, traumatically, or surgically).
2. Use modifier 53 when:
    a. The service was discontinued (stopped mid-stream) because the patient experienced a life-threatening condition.
    b. The procedure was not able to be completed because of anatomical difficulties (e.g. blockage, poor bowel prep), patient anxiety (which may require general anesthesia in a different setting), or equipment problems.
    c. A repeat procedure is planned later to complete the remainder of the procedure.

Codes, Terms, and Definitions

<u>Acronyms & Abbreviations Defined</u>

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
CARC	=	Claim Adjustment Reason Code
CCI	=	Correct Coding Initiative (see “NCCI”)

Acronym or Abbreviation		Definition
cm	=	Centimeters
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as “E/M” in CPT book guidelines, sometimes also abbreviated as “E&M” or “E & M” in some CPT Assistant articles and by other sources.)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MPFS MPFSD MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
NMR	=	Neuromuscular Reeducation
PT	=	Physical Therapy
RARC	=	Remittance Advice Remark Code
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
RVU	=	Relative Value Unit
TE	=	Therapeutic Exercises
UB	=	Uniform Bill
XR	=	X-ray (Radiology)

Definition of Terms

Term	Definition
Precipitous Delivery	The patient delivers the baby vaginally prior to admission or prior to the physician/midwife’s arrival.

Modifier Definitions:

Modifier	Modifier Description & Definition
52	**Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. 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. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use.)

Modifier -52 identifies that the service or procedure has been partially reduced or eliminated at the physician's discretion. The basic service described by the procedure code has been performed, but not all aspects of the service have been performed.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

When modifier -52 is used to indicate reduced services, the billing office must indicate what was different about the procedure (how was the service reduced) and approximately what percentage of the usual work was completed and/or not done.

- In some simple cases, this can be done with a brief statement of additional information on the claim itself. Most electronic clearinghouse services have fields to accommodate and transmit this additional information.
  - If the procedure code is time-based (e.g., "each 15 minutes" or "each additional hour"), indicate on the claim how much time the procedure or service was actually performed.
  - If less than the specified number of views were performed for a radiology procedure code, ensure that no other code exists for the number of views done, and indicate on the claim the number of views performed (e.g., 74010-52 "two views").
  - When an inherently bilateral procedure is performed unilaterally, a claim notation can be made to indicate the procedure was only performed on one side (e.g., 93921 "left leg only", 92556 "right ear only").
- If the nature and extent of the reduction cannot clearly and completely be explained with a notation on the claim itself, then a letter or statement must be attached to the claim, and the medical records documenting the service must also accompany the claim (e.g., operative report, radiology report, visit notes, etc.). Generally, this means that the claim cannot be submitted electronically and must drop to manual submission.

Inappropriate Use of Modifier -52

Modifier -52 may not be used if there is another specific procedure code that appropriately describes the lesser or reduced service that was actually performed; the other procedure code is the most appropriate code and must be reported.

Modifier -52 may not be used when the *full service* is performed but the total fee for the service is reduced or discounted. No CPT modifier exists for a reduced *fee. (AMA*[2]) When fees for vaccines are reduced because the vaccine supply was obtained from a state agency, modifier SL *State supplied vaccine* is the correct modifier to be used.

"If 2 procedures only differ in that 1 is described as an "incomplete" procedure and the other as a "complete" procedure, the "incomplete" procedure is included in the "complete" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites." (CMS[12])

Cross References

A. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.

B. "Maternity Care." Moda Health Reimbursement Policy Manual, RPM020.

C. "Modifiers 73 & 74 - Discontinued Procedures For Facilities." Moda Health Reimbursement Policy Manual, RPM049.

References & Resources

1. American Medical Association. "Appendix A – Modifiers." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.

2. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, Spring 1991, p. 7.

3. American Medical Association. "Modifiers Used with Surgical Procedures". *CPT Assistant*. Chicago: AMA Press, Fall 1992, p. 15.

4. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, November 1996, p. 19.

5. American Medical Association. "Modifiers, Modifiers, Modifiers: A Comprehensive Review". *CPT Assistant*. Chicago: AMA Press, May 1997, p. 1.

6. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, January 2000, p. 5.

7. American Medical Association. "Modifier Update-New and Revised Modifiers for Outpatient Use". *CPT Assistant*. Chicago: AMA Press, May 2000, p. 1.

8. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § E, "Modifiers and Modifier Indicators", pp I-10 – I-14.

9. CMS, Medicare Claims Processing Manual, pub. 100-04, Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services, §20.2, 20.3, 20.4, & 20.5.

10. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. Chicago: AMA Press, 2004, pp. 105-109.

11. "Choosing between Modifier 53 and 52 (Gastroenterology example)." Next Services. Published: March 29, 2017; Last accessed: March 2, 2021. https://www.nextservices.com/choosing-between-modifier-53-and-52-gastroenterology-example/#:~:text=By%20definition%2C%20modifier%2053%20is,52%20can%20sometimes%20be%20confusing.

12. CMS. "More Extensive Procedure." *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § L.6.

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other

professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
10/12/2022	Formatting/Update: Change to new header; includes Idaho. Acronym table: 5 entries added.
7/6/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
9/13/2007	Original Effective Date (with or without formal documentation). Policy based on CMS manual pricing policy for modifier 52 & our administrative decisions.