Reimbursement Policy for Reduced Services and Discontinued Procedures, 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 Overview

This reimbursement policy is applicable to all healthcare services billed on UB04 forms (CMS 1450) and CMS 1500 forms. Our reimbursement policy is developed by considering various factors such as coding methodology, industry-standard reimbursement criteria, regulatory mandates, benefits design, and other relevant considerations.

In accordance with the guidelines outlined in the Current Procedural Terminology (CPT®) book, it is important to note that, under specific circumstances, a healthcare service or procedure may be partially reduced or eliminated at the discretion of the physician or other qualified healthcare professional. In such cases, the service provided should be identified using its standard procedure code, along with the addition of Modifier 52 (Reduced Services) to indicate that the service has been reduced. This allows for the reporting of Reduced Services without altering the identification of the basic service.

Modifier 52 is primarily used to signify the partial reduction or discontinuation of services such as radiology procedures and other procedures that do not require anesthesia. However, it is important to refrain from using Modifier 52 if a portion of the intended procedure has been completed and a corresponding code exists that represents the completed portion of the intended procedure."

Reimbursement Guidelines

Reduced Services

There are no established industry standards for reimbursement of claims billed with Modifier 52 by the Centers for Medicare and Medicaid Services (CMS) or other professional organizations. At Molina Healthcare, our standard for reimbursing claims with Modifier 52 is set at 50% of the Allowable Amount for the unmodified procedure.

It is important to note that Modifier 52 should not be utilized to report the elective cancellation of a procedure prior to anesthesia induction, intravenous (IV) conscious sedation, or surgical preparation in the operating suite. Additionally, it is not appropriate to use Modifier 52 in conjunction with an evaluation and management (E/M) service.

Discontinued Procedures

The term 'Discontinued Procedure' refers to a surgical or diagnostic procedure delivered by a physician or other healthcare professional, which falls short of the standard requirements outlined in the Current Procedural Terminology (CPT®) book.

- **Professional Claims:** Discontinued Procedures are indicated using Modifier 53 (Discontinued Procedure). Modifier 53 signifies that a physician chose to terminate a surgical or diagnostic procedure due to extenuating circumstances that posed a risk to the patient's well-being. It's important to note that Modifier 53 should not be applied if a portion of the intended procedure was completed and there exists a corresponding code for that completed portion. It's worth mentioning that there are no established industry standards for the reimbursement of claims using Modifier 53, whether from the Centers for Medicare and Medicaid Services (CMS) or other professional organizations. At Molina Healthcare, our standard reimbursement rate for claims involving Modifier 53 is set at 33% of the Allowable Amount for the unmodified procedure. Please keep in mind that Modifier 53 is not applicable for facility billing and cannot be used in conjunction with E&M (Evaluation & Management) or time-based codes
- **Facility Claims:** In a facility setting, Discontinued Procedures are reported using either Modifier 73 or Modifier 74. If the procedure was discontinued before the administration of anesthesia, you should append Modifier 73. In such cases, reimbursement will be at 50% of the Allowable Amount for the unmodified procedure. However, if the procedure was discontinued after the administration of anesthesia, you should append Modifier 74, and reimbursement will be at 100% of the Allowable Amount for the unmodified procedure. Please note that Modifiers 73 and 74 are exclusively utilized to signify Discontinued Procedures in cases where anesthesia is either planned or provided. They 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.

State Exceptions

State	Exception
Florida	FL Medicaid reimbursement for modifier 53 is 50%
Kentucky	KY Medicaid is exempt from the Discontinued Procedure Policy. The 53 modifier is not reimbursable.
New York	NY Medicaid does not recognize modifier 53.
Washington	WA Medicaid reimbursement for modifier 53 is 50%
AZ	AZ Is Exempt from this Molina Policy

Documentation History

Type	Date	Action
Published	09/01/2023	
Revised Date		

References

This policy was developed using.

- State Contracts
- Individual state Medicaid regulations, manuals & fee schedules
- American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS (Healthcare Common Procedure Coding System) Release and
- Code Sets
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