Clover

Reduced Services and Discontinued Procedures Reimbursement Policy

Policy # RP-077

Policy Title	Reduced Services and Discontinued Procedures Reimbursement Policy
Policy Department	Payment Strategy & Optimization
Effective Date	10/1/2022
Revision Date(s)	
Next Review Date	

Disclaimer:
Clover Health applies The Center for Medicare and Medicaid Services (CMS) criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

This policy describes Clover's reimbursement policy for reduced services and discontinued procedures. As stated 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 healthcare professional. This will be reported by billing with the appropriate modifier.

Definitions:

- Allowable Amount
  - Defined as the dollar amount eligible for reimbursement to the physician or other qualified healthcare professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, 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.

- Reduced Services
  - Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified healthcare 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.

Policy:

The policy describes when, under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified healthcare professional. In these situations the service provided can be identified by its usual procedure code and with the addition of Modifier 52 (Reduced Services), to indicate that the service is reduced. This provides a method 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.

The use of Modifier 52 is not appropriate 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 52 from the Centers for Medicare and Medicaid Services (CMS) or other professional organizations. Clover Health's standard for reimbursement of Modifier 52 is 50% of the Allowable 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.
Nor should it be used with an evaluation and management (E/M) service.

When billing for a Discontinued Procedure, this word designates a surgical or diagnostic procedure provided by a physician or other health care professional that was less than usually required for the procedure and would be reported by appending Modifier 53.

The modifier indicates that the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. Modifier 53 is not appropriate to use 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. Clover Health's standard for reimbursement of Modifier 53 is 50% of the Allowable Amount for the unmodified procedure.

Billing with Modifier 52 and 53 is not appropriate for facility billing and is invalid when billed with E&M or time-based codes.

Claim Codes (if applicable)	• **Modifier 52**
	  ○ is outlined for use with surgical or diagnostic CPT codes in order to indicate reduced or eliminated services.
	• **Modifier 53**
	  ○ is used due to certain situations when a physician or other qualified healthcare professional elects to terminate a surgical or medical diagnostic procedure for extenuating circumstances when the well-being of the patient is at risk.

References
Medicare Claims Processing Manual - Chapter 04 - Part B Hospital (Including Inpatient Hospital Part B and OPPS): Section 20.6.4, 20.6.6

Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Section 20.4.6, 30.1, 30.6.1, 40.2, 40.4A
Medicare Claims Processing Manual - Chapter 13 - Radiology Services and Other Diagnostic Procedures: Section 80.1
Medicare Claims Processing Manual - Chapter 23 - Fee Schedule Administration and Coding Requirements: Addendum