

Reduced Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

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

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

*CPT® is a registered trademark of the American Medical Association

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

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 the reduced services without disturbing the identification of the basic service.

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.

Reimbursement Guidelines

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. UnitedHealthcare Community Plan's 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.

State Exceptions

Missouri	MO will follow fee schedule reimbursement instead of the reimbursement policies modifier percentage.
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Definitions

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 percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
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Questions and Answers

1	<p>Q: Is the 50% reimbursement level recommended by professional organizations such as Centers for Medicare and Medicaid Services (CMS)?</p> <p>A: CMS takes no stand on the reduced reimbursement percentage for the Modifier 52; however, CMS requires documentation to be submitted with the claim. Claims for surgeries billed with Modifier 52 are priced by CMS on an individual basis only after a review of required documentation.</p>
2	<p>Q: Is it appropriate to report Modifier 52 with radiologic studies or diagnostic services, e.g., post-reduction, post-intubation, post-catheter placement, angiogram, etc.?</p> <p>A: Yes, to communicate a reduced level of such a service it is appropriate to report the CPT or HCPCS code with Modifier 52 appended.</p>

Resources

Individual state Medicaid regulations, manuals & fee schedules
 American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
 Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

History

5/8/2020	Policy Version Change Definitions section: Removed Modifier 52 code description History Section: Entries prior to 1/1/2018 archived
3/17/2020	Policy Version Change State exceptions section: Removed reference to Louisiana Removed all references to Louisiana contained in the body of the policy, information has been moved to the "Louisiana Only" policy
11/1/2019	Annual Anniversary Version Change Title Section: Removed Annual Approval information & moved policy # to the header History Section - Entries prior to 1/1/2017 archived
9/15/2018	Application section updated per legal update

10/24/2006	Policy implemented by UnitedHealthcare Community & State
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