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 Value & Balance Exchange reimbursement policies may 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 Value & Balance Exchange's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Value & Balance Exchange 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 Value & Balance Exchange enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, 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 Value & Balance Exchange due to programming or other constraints; however, UnitedHealthcare Value & Balance Exchange strives to minimize these variations.

UnitedHealthcare Value & Balance Exchange 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.

Application

This reimbursement policy applies to UnitedHealthcare Value & Balance Exchange 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, 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 Value & Balance Exchange'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.

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.

Questions and Answers	
1	**Q:** Is the 50% reimbursement level recommended by professional organizations such as Centers for Medicare and Medicaid Services (CMS)? **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.
2	**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.? **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.

Resources

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	
1/1/2021	Policy implemented by UnitedHealthcare Value & Balance Exchange

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