REDUCED SERVICES POLICY (CES)

Policy Number: ADMINISTRATIVE 170.17C T0 **Effective Date**: June 1, 2020

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Related Policies

None

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

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

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. Oxford'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 Allowable Amounts, 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.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2020R0065A*]

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.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
06/01/2020	**Definitions** • Removed definition of "Modifier 52" **Supporting Information** • Archived previous policy version ADMINISTRATIVE 170.16C T0