

	Policy Number: 1005
	Subject: Reduced and Discontinued Procedures
	Impact: Reimbursement
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Primary Authors: Code Governance Committee Effective Date: 10/01/2019	Origination Date: 6/12/2019 Review Frequency: Yearly Review Coordinator:
Review Dates: 6/12/2020	Committees: Code Governance

Policy: Reduced and Discontinued Procedures

Purpose

The purpose of this Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes. Claims should be coded appropriately according to industry standard coding guidelines (including, but not limited to, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Fee determinations will be based on the applicable provider contract language and WPS/Arise/Aspirus Arise reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.

Overview

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent. This policy applies to all products and all network and non-network physicians and other qualified health care professionals.

1. 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.
2. The term "Discontinued Procedure" designates a surgical or diagnostic procedure provided by a physician or other health care professional that was less than usually required for the procedure as defined in the Current Procedural Terminology (CPT®) book. Discontinued Procedures are reported by appending Modifier 53. It is not appropriate to use Modifier 53 if a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.



Reimbursement Guidelines

1. WPS/Arise/Aspirus Arise 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.
2. Under certain circumstances, such as a serious risk to the patient's well-being, a surgical or diagnostic procedure is terminated at the physician or other health care professional's direction. Under these circumstances, the procedure provided should be identified by its usual procedure code and the addition of Modifier 53 (Discontinued Procedure) signifying that the procedure was started but discontinued. This provides a means of reporting the Discontinued Procedure, leaving the identification of the basic service intact. According to the Centers for Medicare & Medicaid Services (CMS) and CPT coding guidelines, Modifier 53 should be used with surgical codes or medical diagnostic codes. Modifier 53 should not be used with:
 - Evaluation and management (E/M) services.
 - Elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.
 - When a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure.

WPS/Arise/Aspirus Arise standard for reimbursement of Discontinued Procedures with Modifier 53 is 50% of the Allowable Amount for the primary unmodified procedure. Multiple procedure reductions will still apply.

