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Origination: October 11, 2019
Last Review: October 17, 2024
Next Review: October 17, 2024
Effective Date: February 01, 2025

Description

Provide guidelines for the payment of eligible services appropriately appended with medical billing modifier -52 for professional and outpatient facility claims.

Policy & Guidelines

Policy Statement

Effective with dates of service on or after October 11, 2019, Blue Cross and Blue Shield of Vermont (Blue Cross VT) payment for services associated with use of modifier -52 will be considered based on applicable criteria set forth below in this policy.

Definition(s)

Per the American Medical Association (AMA) 2024 CPT® Professional Manual Appendix A:

> *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, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.*
>
> ***Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers- 73 and- 74 (see modifiers approved for ASC hospital outpatient use).*

Reimbursable Services

Blue Cross VT will pay for reduced services appropriately appended with modifier -52 the allowed amount will be the lesser of (a.) 50 % of the fee schedule or contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the providers allowed charges. When billing with modifier- 52 refer to Addendum A.

Provider Billing Guidelines and Documentation

The provider should ensure the rationale for appending the modifier is documented in the member's medical record. The submission of modifier -52 appended to a procedure code indicates that the documentation is available in the member's medical records which support the service resulted in the decision to append the -52 modifier to the procedure and that medical records will be provided in a timely manner to review upon request.

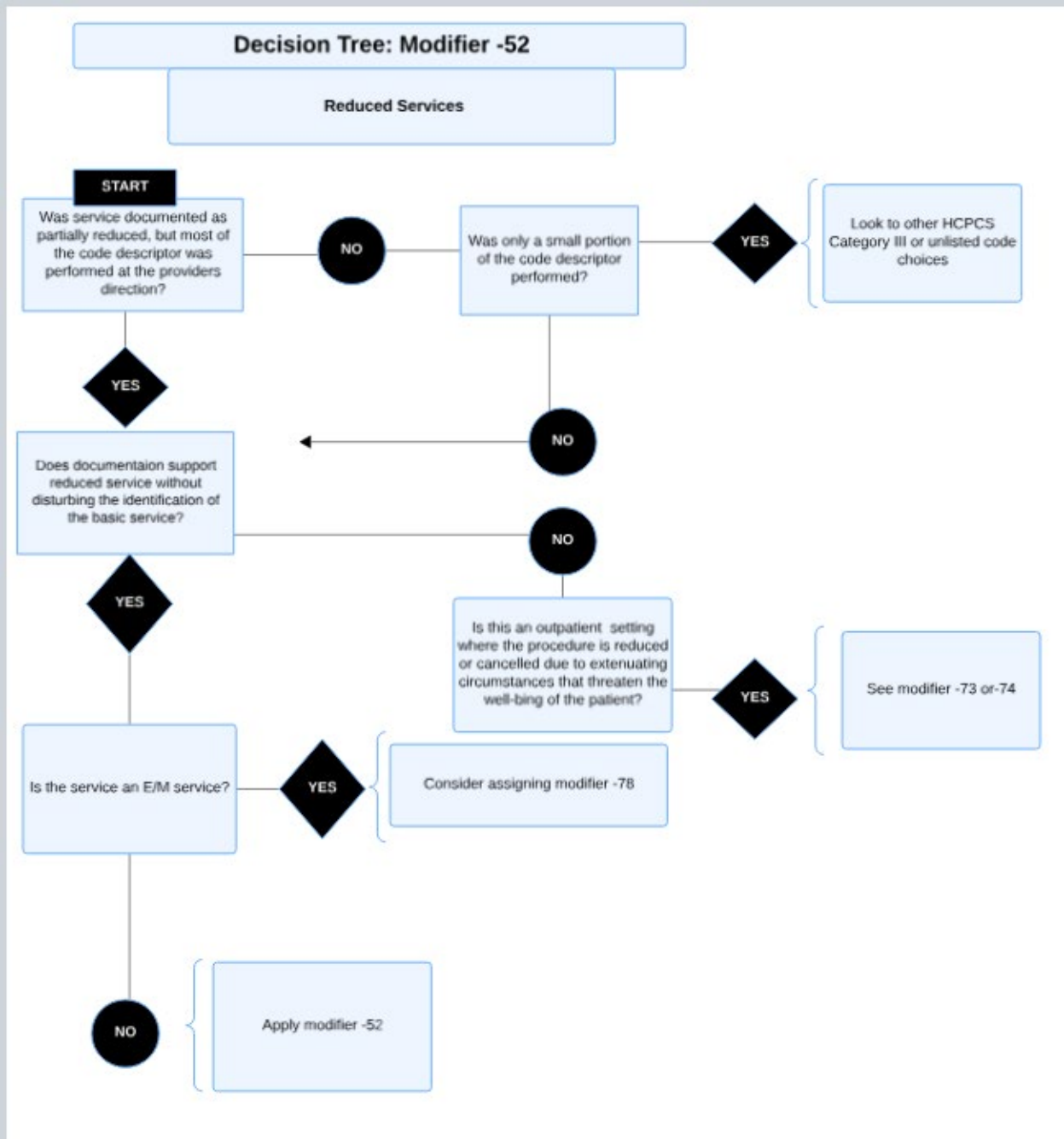
Correct Use of Modifier -52

When a provider performs a procedure less than the CPT code descriptor, indicate this by appending modifier -52. This modifier shows that a procedure required significantly less work that the code's definition would indicate as the normal situation. This modifier is most often used to indicate that only apportion of the elements of a given procedure were completed.

Use -52 modifier to indicate a service or procedure is partially reduced or eliminated at the providers election.

For additional guidance on when to use modifier -52, please refer to Table 1 Modifier Decision Tree.

Table 1: -52 Modifier Decision Tree



Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

N/A

Related Policies

N/A

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

References

American Medical Association. (2024). Current Procedural Terminology (CPT). Appendix A – Modifiers. Chicago: AMA Press.

American Medical Association. (2024). Current Procedural Terminology (CPT). Surgery Guidelines. Chicago: AMA Press. icy Implementation/Update Information.

Grider, Deborah J. (2004). Coding with Modifiers: A Guide to Correct CPT® and level II Modifier Usage. Chicago IL: American Medical Association.

Policy Implementation/Update Information

This policy was originally implemented on October 11, 2019.

Date of Change	Effective Date	Overview of Change
October 11, 2019	October 11, 2019	Payment policy originally implemented
October 17, 2024	February 01, 2025	Payment policy updated new template format, references and section of correct use of modifier added. Minor editorial refinements to policy statements; intent unchanged.

Approved by **Update Approved: 10/17/2024**

Tom Weigel, MD, Chief Medical Officer

Addendum A

Modifier Payment Table

Modifier	
-52 Modifier	**[Reduced Services]**
Blue Cross VT will pay for reduced services appropriately appended with modifier -52 the allowed amount will be the lesser of (a.) 50% of the fee schedule or contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the provider's allowed charges.	