BlueCross BlueShield of Vermont
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MODIFIER 52
Corporate Payment Policy
New Policy APPROVED 10.11.2019

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Document Precedence

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

1) To the extent that there may be any conflict between the BCBSVT 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 BCBSVT 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 BCBSVT 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 BCBSVT Payment Policy Manual and BCBSVT's claim editing solution, BCBSVT's claim solution takes precedence.

Payment Policy

Description

Background

Providers are responsible for correct and accurate billing, including proper use as defined in the current manuals, including: American Medical Association (AMA) Current Procedural Terminology (CPT©), Health Care Procedure Coding System (HCPCS), and the most recent International Classification of Diseases Clinical Modification (ICD-10-CM).

The CPT® code set nomenclature uses modifiers as an integral part of its structure. A modifier provides a means by which a qualified heath care professional can indicate that a service or procedure was altered by a specific circumstance(s), however, there was no change in the code description.

Modifiers are essential tools in the coding process. The AMA developed HCPCS Level I modifiers, which are numeric. The Center for Medicare and Medicaid Services (CMS) developed HCPCS Level II alphabetic and alphanumeric modifiers to be used with codes to further clarify the various circumstance(s) of procedure and/ or services. Modifiers enhance a code narrative to describe surrounding circumstances as they apply to each individual patient that are unique. Modifiers are vital to efficiently communicate between the rendering physician or other qualified health care professional and to BCBSVT. Modifiers do not ensure reimbursement.

Modifiers are used to report or to indicate information, such as the anatomical site, discontinued procedure, state-supplied vaccine, rental item, or performance by more than one physician and/or in one more than one location to the code. Additionally, modifiers help to eliminate duplicate billing and inappropriate unbundling. Modifiers are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data.

Some modifiers may increase or reduce reimbursement, whereas other are only informational. There may be times when a procedure requires less effort than typically warranted and other times a procedure may require some additional effort.

Policy: CPT® Modifier 52: Reduced Service

Per AMA's 2019 CPT® Professional Manual: "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)."

BCBSVT will reimburse reduced services appropriately appended with modifier 52 at 50% (fifty percent) of the applicable BCBSVT fee schedule amount for the unmodified service. When billing with modifier 52, the provider should ensure the rationale for appending the modifier is documented in the patient's medical record. For additional guidance on when to use modifier 52, please refer to the Decision Tree provided as Attachment 1 to this policy.

Eligible Services – This Policy applies to all professional and facility services performed by network and non-network physicians and other qualified health care professionals.

Benefit Determination Guidance

Payment for services using the modifier 52 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 using the modifier 52 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 (BCBSVT 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.

Provider Billing Guidelines and Documentation

Claims for services using the modifier 52 are accepted on either the CMS-1500 or UB-04 claim forms.

To ensure correct processing and payment for services using the modifier 52, wherever possible, the first individual claim line should include the service(s) which is using the modifier 52.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

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. The policy does not apply to Hub and Spoke claims.

Employer Group Exclusion(s)
N/A

Audit Information
BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines
N/A

Related Policies
N/A

Policy Implementation/Update Information
New policy effective January 1, 2020

References/Resources

American Medical Association. (*2019). CPT®: Current Procedural Terminology (Professiona*l). Chicago IL: American Medical Association.

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

Maguire, Nancy. (2004). *Break Through the Modifier Maze*. Rockville, Maryland: DecisionHealth.

Optum 360®. (*2019). HCPCS Level II (Expert)* Optum 360®.

Approved by **Date Approved**: 10.11.2019

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