REDUCED AND DISCONTINUED SERVICES

File Name: reduced_and_discontinued_services
Origination: 03/2024
Last Review: 03/2024
Next Review: 04/2025

Description

Per 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. Additionally, under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Providers and facilities indicate the reduction or partial elimination of services using Modifier 52 (reduced services). Providers indicate the procedure was started but discontinued using Modifier 53 (Discontinued Procedure). Facilities indicate the procedure was discontinued prior to administration of anesthesia using Modifier 73 (Discontinued Outpatient Hospital/Ambulatory Surgery Center [ASC] Procedure Prior to the Administration of Anesthesia).

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) allows professional and facility reimbursement for reduced or discontinued services when submitted with the appropriate modifier. Reduced and discontinued services will receive 50% of the allowed reimbursement, according to the criteria outlined in this policy.

Reimbursement Guidelines

Professional and facility services partially reduced or eliminated must be appropriately submitted with Modifier 52. For services that were started but discontinued, Modifier 53 must be appropriately submitted for professional billing, and Modifier 73 must be appropriately submitted for facility billing.

Multiple procedure reductions will still apply.

Modifiers 52, 53 and 73 are not appropriate for the following services and scenarios:

- Evaluation and management (E/M) services
- A service is changed or converted to a different procedure
- Elective cancellation of a service prior to anesthesia induction, (IV) conscious sedation, and/or surgical preparation in the operating suite
- An existing code represents the completed portion of the reduced or discontinued service

Modifier 53 is not applicable for facility provider billing. Modifier 73 is not applicable for professional provider billing.

Rationale

In alignment with CMS and correct coding initiatives, Blue Cross NC will reduce reimbursement for services filed with modifiers 52, 53 or 73.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com .

CPT® Code / Modifier	Description
Modifier 52	Reduced Services
Modifier 53	Discontinued Procedure
Modifier 73	Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure prior to the administration of anesthesia.

Related policy

Modifier Guidelines

References

American Medical Association, Current Procedural Terminology (CPT®)

Medicare Claims Processing Manual CMS Chapter 12

History

03/01/2024	Combined Reduced Services and Discontinued Services into one policy. Updated policy language around professional and facility applicability for modifier 52. RPOC approved. **Notification on 1/01/2024 for effective date 03/01/2024.** (ss)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.