Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Reimbursement for Reduced and Discontinued Services		
Effective Date: **08/31/17**	Committee Approval Obtained: **10/31/19**	Section: **Coding**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. The following

	modifiers can be appended for reduced and discontinued services, if applicable: • **Modifier 52**: indicates surgical procedures for which services performed are partially reduced or eliminated; reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate; do not report Modifier 52 on evaluation and management (E&M) and consultation codes • **Modifier 53**: indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances or that threatened the well-being of the patient; reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate; Modifier 53 is not applicable for facility billing and is not valid when billed with E&M or time-based codes • **Modifier 73**: indicates the physician cancelled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient; reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate; Modifier 73 is not applicable for professional provider billing • **Modifier 74**: indicates a procedure was stopped after the administration of anesthesia or after the procedure was started; reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate; Modifier 74 is not applicable for professional provider billing If the reduced or discontinued procedure is performed with an assistant surgeon or in conjunction with multiple surgeries, assistant surgeon and/or multiple procedure rules and fee reductions apply. We reserve the right to perform post-payment review of claims submitted with Modifiers 52, 53, 73 and 74.
History	• Biennial review approved and effective **10/31/19**: Modifier 52 description updated for clarity • Biennial review approved and effective **08/31/17:** Policy language updated; Policy template updated • Biennial review approved and effective **04/27/15**: Policy language updated • Initial policy approval and effective date **01/01/15**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract • Optum 360, 2019 edition

Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Assistant at Surgery (Modifiers 80/81/82/AS) • Modifier Usage • Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None