JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.020
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		Approval Date	05/29/2024
	Subject **Reduced Procedures (Modifier 52)**	*Supersedes Date*	08/01/2020
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		Page	1 of 4

This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Modifier 52 , Reduced Procedures, Reduced Services

Table of Contents		Page Number

I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory

mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

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

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

The purpose of this policy is to provide basic billing guidance when Modifier 52 is reported with a procedure. JHHP aligns with CMS guidance for Modifier 52, which is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia. Providers must submit a clean claim that is received in a timely manner and includes all the information we need to process it for payment appropriately.

III. POLICY STATEMENT

This policy is applicable for both participating and nonparticipating providers who render services to JHHP members and submit claims to JHHP. JHHP allows reimbursement (when billed correctly), for reduced procedures appended with the appropriate modifier. Documentation may be reviewed to determine if the billed procedures meets plan coverage criteria and applicable coding guidelines for the use of modifier 52. JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/ or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. GENERAL BILLING GUIDELINES and PAYMENT METHODOLOGY

A. When appending modifier 52 to a procedure code, indicate statement "reduced services" in Item 19 in CMS-1500 claim form (or electronic equivalent).
B. When billed appropriately, JHHP will reimburse covered services, reported with modifier 52 (reduced services) at 50% of the contracted rate.
C. If the portion of the procedure that was completed can be represented by another procedure code, JHHP requires the provider to bill for the applicable procedure code instead of billing modifier 52.
D. Surgeries for which services performed are significantly less than usually required may be billed with modifier -52.
E. Providers may report modifier 52 to indicate partial reduction of services for which anesthesia is not planned.
F. When another modifier that reduces the fee schedule amount is also applicable, Modifier 52 must be reported in the second position.
G. Modifier 52 may be submitted with radiology services in which the "supervision" and "interpretation" (S&I) components are performed by different providers and there is no CPT/HCPCS code that describes the portion of the service provided. The services should be submitted with the appropriate modifier based on the supervision (TC) or interpretation (26), followed by CPT modifier 52.

i. In situations in which a cardiologist bills for the supervision (the “S”) of the S&I code, and a radiologist bills for the interpretation (the “I”) of the code, both physicians should use a “-52” modifier indicating a reduced service; (e.g., only one of supervision and/or interpretation.). This guidance does not apply if one provider has already submitted a claim and been reimbursed for both the "supervision" and "interpretation" component.

H. In accordance with CMS, JHHP will apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia.

I. Ambulatory surgical centers (ASC) may use modifier 52 to indicate the discontinuance of a procedure not requiring anesthesia.

i. ASC services billed with modifier -52 modifier are not subject to the multiple procedure reduction.

V. INAPPROPRIATE BILLING OF MODIFIER 52

1. Do not report modifier 52 for the following:
   - Evaluation and Management (E/M) services
   - With the CPT code for the reduced procedure
   - Partial services furnished as split (or shared) visits.
   - Unlisted Codes
   - Time-based codes
   - When the services or procedure is discontinued after anesthesia is administered to the patient.
   - The elective cancellation of a procedure prior to the member’s anesthesia induction and/or surgical preparation in the operating suite. Elective cancellations include the member not showing, the member’s noncompliance, the member deciding not to have the procedure, or rescheduling initiated by either the facility or the member.
   - Procedure codes for any other procedure not performed
   - The termination of a procedure
2. Do not confuse with "terminated procedure" modifier 53.

VI. DOCUMENTATION GUIDELINES

1. Each medical record must include documentation that includes (but not limited to) the following:
   - A concise statement about how the service differs from the usual; and
   - Detailed operative report with the claim.
   - Additional information to support the modifier can be written in the narrative of claim.
   - State when the procedure was started and stopped.
   - Thoroughly explain why the procedure was discontinued.
   - Notate the percentage of the procedure that was performed.
   - JHHP plans may conduct medical record documentation reviews on a randomly selected sample of practitioners or providers who deliver services outside their regular scope of practice or assigned specialty.
   - Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.

VII. EXCEPTIONS and EXCLUSIONS

1. When applicable, Maryland Waiver Providers are required to bill services in accordance to the Health Services Cost Review Commission (HSCRC) rules and regulations, and will be reimbursed under the HSCRC payment methodology.
2. **PPMCO**- JHHP will process and reimburse claims in accordance with Maryland Medicaid guidance. Please consult the authoritative guidance found on the Maryland Medicaid website to obtain additional specific information on policy, benefits, and coverage, not adressed in this policy.

i. JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
ii. Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
iii. Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

3. **USFHP:** JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

VIII. CODES, TERMS and DEFINITIONS

Modifiers

Modifier	Definition
52	Reduced Services; Under certain circumstances, a service or procedure is partially reduced or eliminated at the provider's discretion.

IX. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Maryland Medicaid Professional Services Provider Manual
- Medicare Claims Processing Manual CH. 12 - Physicians/Nonphysician Practitioners
- Medicare Claims Processing Manual CH. 13- Radiology Services and Other Diagnostic Procedures
- TRICARE Reimbursement Manual

X. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
5/29/2024	Revision	Updated: policy formatting; language and billing guidance; references.	Reimbursement Policy Committee (RPC)