Aetna Better Health® of Florida
261 N. University Drive
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aetna™

NEW POLICY UPDATES

CLINICAL PAYMENT, CODING AND POLICY CHANGES

We regularly augment our clinical, payment and coding policy positions as part of our ongoing policy review processes. In an effort to keep our providers informed, please see the below chart of upcoming new policies.

Effective for dates of service beginning April 1st, 2020:

Modifier Policy

Reduced and Discontinued Services Modifiers-Use of Modifier 52 with Radiologic Supervision and Interpretation (S&I) Services-Radiologic supervision and interpretation (S&I) describe the supervision of the radiologic portion of a procedure and the interpretation of the findings by one or more physicians. The physician must be present during the supervision of the procedure, but the interpretation of the procedure may be performed at a later time by another physician. According to CMS policy, when one physician performs the supervision and another performs the interpretation, modifier 52 must be appended to both physician's services.

Modifier 52 or 73 with Bilateral Procedures-Planned bilateral procedures that have a reduced service (Modifier 52) or are discontinued prior to administration of anesthesia (Modifier 73) are not entitled to be reimbursed at 150% (bilateral rate) by CMS guidelines. In this scenario the bilateral modifier (50) will be disregarded as far as reimbursement is concerned.

Maximum Units for Modifier 52 or 73-According to CMS Policy, procedures that are reduced services (modifier 52) or discontinued prior to administration of anesthesia (modifier 73) may not be billed with units greater than one.

Consistency of Reduced or Discontinued Services Between Professional and Facility Providers-According to the AMA CPT Manual, modifiers 52 and 53 are used by a physician or other qualified health care professional to report a service or procedure that has been partially reduced or discontinued. Modifiers 73 and 74 are used by an outpatient facility to report a surgical or diagnostic procedure that has been discontinued, either before or after anesthesia has been administered.

- 52 (Reduced services)
- 53 (Discontinued procedure)
- 73 (Discontinued outpatient/ASC procedure prior to the administration of anesthesia)
- 74 (Discontinued outpatient/ASC procedure after administration of anesthesia)

There should be consistency between the professional claim and the outpatient facility claim when these reduced or discontinued services are reported. When an outpatient facility claim has been received indicating that the procedure was discontinued, the physician or other qualified health care professional should also indicate that the service was discontinued.

If you have any questions, please call our Provider Relations Department at 1-800-441-5501 (Medicaid/Healthy Kids) or 1-844-645-7371 (LTC).

Proprietary