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Origination: October 11, 2019
Last Review: October 16, 2025
Next Review: October 16, 2027
Effective Date: January 1, 2026

Description

Provide a payment policy statement and guidelines that address the claims processing and payment for eligible services submitted with procedure codes appended with the following modifiers: **-52** [Reduced Services], **-53** [Discontinued Procedure], **-73** [Discontinued Outpatient Procedure Prior to Anesthesia administration], **-74** [Discontinued Outpatient Procedure After Anesthesia Administration] for professional and outpatient facility claims.

Policy & Guidelines

Policy & Guidelines

According to the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. It may also provide more information about a service such as it was performed more than once, unusual events occurred, or it was performed by more than one provider and/or in more than one location.

Policy Statement

Effective dates of service:

[for modifier-52] on or after October 11, 2019, [for modifier-53] on or after January 01, 2021,

[for modifier-73] on or after January 13, 2023, [for modifier-74] on or after January 13, 2023,

Blue Cross and Blue Shield of Vermont (Blue Cross VT) may process payment for eligible services with procedure codes submitted may be considered based on applicable criteria set forth below in this policy. Additionally, effective with dates of service on or after January 1, 2026, Blue Cross VT processes payment for eligible services with procedure codes submitted with modifiers -52, -53, -73 or -74 in accordance with AMA and the CMS guidelines.

Eligible

- Blue Cross VT may pay for services appropriately appended with modifier -52. The allowed amount will be the lesser of (a.) 50 % of the contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the providers allowed charges. When billing with modifier- 52 refer to **Addendum A.**

- Blue Cross VT may pay for services appropriately appended with modifier -53. The allowed amount will be the lesser of (a.) 50 % of the contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the providers allowed charges. When billing with modifier- 53 refer to **Addendum A**.

- Blue Cross VT may pay for services appropriately appended with modifier -73. The allowed amount will be the lesser of (a.) 50 % of the contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the providers allowed charges. When billing with modifier - 73 refer to **Addendum A.**

- When billing with modifier -74 refer to **Addendum A.**

Not Eligible

Examples of inappropriate use of the modifiers include the following.

- Modifier -53 is not valid for use with an Evaluation and Management service (E/M). When an E/M service is billed with modifier -53, the E/M service will be denied provider liability.
- The Centers for Medicare and Medicaid Services (CMS) describe when they consider appropriate use of modifier -52 with radiologic supervision and interpretation (S&I) services and payment guidelines for these circumstances. Blue Cross VT expects providers to follow these guidelines and will not pay claims with modifier -52 that fail to adhere to these guidelines. Note: Consistent with CMS guidelines, when one physician performs the supervision and another performs the interpretation, modifier -52 must be appended to both physicians' services. Therefore, when two different physicians bill for the same S&I services, one billing for supervision and the other for interpretation (modifier -26) and modifier -52 is not appended to both, the services will be denied. Provider liability. The combinations of services represented by these S&I codes with and without modifier -26 or modifier -52 will be evaluated and no more than the complete S & I service will be allowed, regardless of the method reported. (Note: that repeat procedures are excluded from this assessment.)
- 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 paid at 150% per CMS guidelines.
- When all of the individual tests within a laboratory panel are not performed, the individual codes should be reported rather than reporting the panel code with modifier -52 or -53 per AMA and CMS policy. Laboratory panel codes when billed with modifier -52 or -53 will be denied provider liability.

- For consistency and cross claim validation, services reported by a professional provider when billed without modifier -52 or modifier -53 when the same code is billed for the same date of service by an outpatient facility with modifier -73 or modifier -74, the professional services will be denied provider liability.
- Anesthesia services (00100-01969, 01991-01992, 01999) billed by a professional provider when any service is billed for the same date of service by an outpatient facility with modifier -73 will be denied provider liability.
- Services billed with modifiers -50, -52 and -73 on the same line will result in the modifier -50 being removed (CMS-1450/ facility billing). Discontinued services will be paid at no more than 50%, consistent with CMS policy.
- Services billed on two lines, one with modifier -50 and one without modifier -50, with modifier -52 or -73 appended to either line, will result in the denial of one of the lines. No more than 50% payment will be made in these instances.
- In the event that a claim for a service with modifier -52 or -73 is submitted after the same service has been previously paid for on a different claim without modifier -52 or -73 (paid historical claim), then the service with modifier -52 or -73 will be denied.
- CMS guidelines provide guidance that modifier -53 is not appropriate when billed by an outpatient hospital facility or an ambulatory surgical center (ASC). Therefore, any service billed with modifier -53 when billed with Bill Type (0120-012X– Inpatient-part B), 0130-013X (Outpatient Hospital), 0140-014X (Outpatient hospital-other), or 0830-083X ASC will be denied provider liability.

Provider Billing Guidelines and Documentation

When reporting codes with more than one modifier, it is vital to sequence the modifiers: First, enter the functional modifier (pricing and or payment modifier) next, enter the informational modifier (or statistical modifier), which clarifies aspects of the procedure or service rendered. If multiple informational modifiers are reported those can be reported in any order, after the primary functional modifier has been entered.

Per the provider handbook the modifier sequencing have certain requirements or have specific payment rules:

1. Modifiers that are not listed as informational must be billed in the first position of the modifier field to process correctly.

2. If a modifier has an impact on pricing, the service line it is reported on must be billed at the full charge,* without any reductions. Our claims processing system uses the billed charge as part of the calculation for payment. If a reduction has already been made, it will further reduce the allowance for the service.

*We define “full charge” as the amount that would be billed if you were performing the complete service.

The provider should ensure the rationale for appending the modifiers contained within this policy is documented in the member's medical record. The submission of any of these modifiers appended to a procedure code indicates that the documentation is available in the member's medical record. The medical record documentation shall support the service resulted in the decision to append the -52, -53, -73 or -74 modifier to the procedure and that medical records will be provided in a timely manner to review upon request.

Benefit Determination Guidance

Payment for services 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 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 (Blue Cross VT 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.

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.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

N/A

Related Policies

CPP_32 Claims Editing Payment Policy
Process to Submit Questions Related to Coding Denial(s)
Provider Handbook/Modifiers

Document Precedence

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

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

References

American Medical Association. (2024). Current Procedural Terminology (CPT®). Surgery Guidelines. Chicago: AMA Press. icy Implementation/Update Information.

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

Medicare Claims Processing Manual, Chapter 13 – Radiology Services and Other Diagnostic Procedures, 80 (Supervision and Interpretation (S&I) Codes and Interventional Radiology.

Pub. 100-04 Medicare Claims Processing

Policy Implementation/Update Information

This policy was originally implemented on October 11, 2019.

Date of Change	Effective Date	Overview of Change
October 11, 2019	October 11, 2019	Payment policy originally implemented
October 17, 2024	February 01, 2025	Payment policy updated new template format, references and section of correct use of modifier added. Minor editorial refinements to policy statements; intent unchanged.
October 16, 2025	January 1, 2026	Payment policy reviewed. Payment policy renamed from "Modifier -52 [Reduced Services]" to "Modifier -52, -53, -73, -74 Reduced, Discontinued Services." Added modifiers -53, -73 and -74 and updated payment policy to provide additional clarity pertaining to section in payment policy CPP_32 Claims editing. Added related policies section of payment policy. Updated references. Removed -52 modifier decision tree and -52 separate section. Added modifiers -53, -73, & -74 to Addendum A. Added language in billing and documentation section to reflect information on sequencing of modifiers and types of modifiers for proper pricing.
November 13, 2025	January 01, 2026	Corrected previous effective dates from past payment policy dates.

Approved by **Update Approved: 11/13/2025**

Tom Weigel, MD

Tom Weigel, MD, Chief Medical Officer

Addendum A

Modifier Payment Table

-52 Modifier	[Reduced Services]
Blue Cross VT may pay for reduced services appropriately appended with modifier -52 the allowed amount will be the lesser of (a.) 50% of the fee schedule or contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the provider's allowed charges.	
-53 Modifier	**[Discontinued Procedure]**
Blue Cross VT may pay for reduced services appropriately appended with modifier -53 the allowed amount will be the lesser of (a.) 50% of the fee schedule or contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the provider's allowed charges.	
-73 Modifier	**[Discontinued Outpatient Procedure Prior to Anesthesia Administration]**
Blue Cross VT may pay for reduced services appropriately appended with modifier -73 the allowed amount will be the lesser of (a.) 50% of the fee schedule or contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the provider's allowed charges.	
-74 Modifier	**[Discontinued Outpatient Procedure After Anesthesia Administration]**
Blue Cross VT considers modifier -74 as informational.	