

	Reimbursement Policy Manual		Policy #:	RPM018
Policy Title:	Modifier 53 – Discontinued Procedure			
Section:	Modifiers	Subsection:	None	
Scope:	This policy applies to the following Medical (including Pharmacy/Vision) plans:			
Companies:	<input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS			
Types of Business:	<input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input type="checkbox"/> Other: _____			
States:	<input checked="" type="checkbox"/> All States <input type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input type="checkbox"/> Oregon <input type="checkbox"/> Texas <input type="checkbox"/> Washington			
Claim forms:	<input checked="" type="checkbox"/> CMS1500 <input checked="" type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)			
Date:	<input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing			
Provider Contract Status:	<input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network			
Originally Effective:	9/13/2007	Initially Published:	2/26/2013	
Last Updated:	5/8/2024	Last Reviewed:	5/8/2024	
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No				
Last Update Effective Date for Texas:		5/8/2024		

Reimbursement Guidelines

A. Modifier 53 is Not Valid or Appropriate When:

1. Modifier 53 is not valid when another (lesser) code is available to describe the portion of the discontinued service which was completed.

Example:

A colonoscopy was planned. Unable to reach the cecum to qualify for colonoscopy code but did reach the sigmoid colon and a polyp was removed within the areas reached.

- 45385 may not be reported with modifier 53.
- A sigmoidoscopy procedure code needs to be reported instead. (Next Service¹³)
Choose the correct procedure code based upon the technique used to remove the polyp:
 - 45333 (Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps)
 - 45338 (Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique)

2. Modifier 53 is not appropriate to use when multiple attempts were required to successfully accomplish the procedure.

a. All attempts to accomplish a procedure during the same patient encounter or operative session are included in the procedure code for the successful procedure. (CMS¹²)

b. Examples (not all inclusive):

i. IUD placement.

1) Procedure note describes: The first two IUDs were placed without difficulty but failed to deploy and were expelled or removed. A different lot number and different size IUD was selected, and the third IUD was placed and deployed normally without issue.

2) Claim submitted:

Codes & Units submitted	Comments
58300 x 1 unit	Successful IUD placement. Reimbursement for this line includes all attempts required in this session for a successful IUD placement.
J7301 x 1 unit	Supply for successfully placed IUD.
58300-53 x 2 units	Incorrect use of modifier 53. Reimbursement for unsuccessful attempts is included in the allowance for the successful procedure.
J7301-53 x 2 units	Incorrect use of modifier 53. 1) Modifier 53 may not be used for supply items. 2) See below for additional notes on IUDs.

3) Additional notes about IUD supply itself:

1. If an IUD is successfully implanted, no more than one unit of an IUD may be billed.
2. If the procedure does not result in a successful IUD placement in the patient, the IUD(s) used in the attempt(s) (e.g., J7301) may not be billed on the claim.
 - a. Defective implants or supplies are to be returned to the supplier for replacement or refund.
 - b. Any dropped or otherwise contaminated implants or supplies may not be reported on the claim. These are a practice expense or cost of doing business and are not eligible for reimbursement.

ii. Placement of esophageal stent (e.g., 43212).

iii. Placement of biliary duct or pancreatic duct stent (e.g., 43274-43276).

iv. Placement of ureteral stent (e.g., 50605, 50693-50695, 50947, 51045, etc.).

v. Placement of intracoronary stent(s) (e.g., 92928-92944).

B. Quantity Limits for Discontinued Procedures

1. Modifier 53 is considered valid on a maximum of one procedure code per date of service.
2. When multiple procedures were planned:
 - a. It is never appropriate to report more than one procedure code with modifier 53.
 - b. When none of the planned procedures is completed, then the first planned procedure is reported with modifier 53. The other planned procedure(s) are not reported.
 - i. Modifier 50 and modifier 53 may not be reported together on the same procedure code.
 - ii. When a bilateral procedure is planned and discontinued before either side is completed, only a unilateral procedure code may be reported with modifier 53.
 - c. If one or more of the procedures planned is completed, the completed procedures are reported as usual. The other procedure(s) that are discontinued or not completed are not reported and are not eligible for separate reimbursement.

Exceptions:

- i. Upper GI and Lower GI procedures, same day:
 - 1) The only time it is appropriate to report a discontinued procedure with modifier 53 in combination with completed procedure codes is when the completed procedures are upper GI endoscopy procedures and the single, discontinued procedure is a lower GI endoscopy, or vice versa.
 - 2) However, it is still not appropriate to report a completed lower GI procedure code in combination with a discontinued lower GI procedure code. In that case, only the completed lower GI code may be reported.
 - ii. Removal and reinsertion of IUD:

If an IUD is successfully removed, and the reinsertion of the new IUD is not successful, both procedures may be reported. (AMA ¹²)

Important Note: Since 58300-53-51 is a secondary procedure, that reduced amount is also subject to multiple procedure rules.

See also information for [coding and reimbursement of unsuccessful IUD placement](#).
3. Providers will be reimbursed for one discontinued procedure with modifier 53. Additional discontinued procedures for the same date of service are not eligible for reimbursement.

C. Documentation Requirements

The medical record must include documentation that the procedure was started, why the procedure was discontinued, and the percentage of the procedure that was performed. This supporting documentation must be available and provided for review upon request.

D. Determining the reduction for modifier 53

1. Any procedure code that has a separate RVU amount listed on the CMS Physician Fee Schedule when modifier 53 is appended (e.g., 45378-53, G0105-53, G0121-53) will be priced based upon a comparison of the RVU for the unmodified code to the RVU for the modifier 53 listing.

For example:

45378-53 is used to report a diagnostic colonoscopy (45378) during which the provider was unable to advance the instrument to the cecum or colon-small intestine anastomosis due to unforeseen circumstances. The CMS Physician Fee Schedule lists a separate RVU/pricing for 45378-53, which is approximately 50% of the RVU for 45378 (unmodified). Accordingly, 45378-53 will be priced at 50% of the allowable amount for the unmodified procedure.

2. Effective for date of service November 15, 2023 and following, if there is no separate RVU listing for the procedure code with modifier 53 appended, the discontinued procedure will be reimbursed at 25% of the usual allowable fee.
3. Effective for dates of service November 14, 2023 and prior, if there is no separate RVU listing for the procedure code with modifier 53 appended, the discontinued procedure will be manually priced, based upon the amount of the procedure work completed. Medical records may need to be reviewed to determine the reduction for pricing.
4. Other Pricing Adjustments Affect Final Line Item Allowable

Please Note: When modifier 53 discontinued services fee reductions apply, other pricing adjustments may also apply before the final allowable amount for each line item is determined. For example, multiple procedure adjustments, bilateral adjustments, assistant surgeon adjustments, co-surgery adjustments, related within global adjustments, etc.

E. Use of Modifier 53 on Facility Claims

1. Modifier 53 is used to indicate discontinuation of physician & professional services only and is not approved for use by outpatient hospital services or ASCs.
2. Procedures reported by ASCs or outpatient hospitals with modifier 53 appended will be denied. This is an invalid use of modifier 53. See RPM049, "Modifiers 73 & 74 - Discontinued Procedures For Facilities." (Moda^B)

F. Selecting Between Modifier 52 and Modifier 53

1. Use modifier 52 when:
 - a. The service was reduced at the physician's discretion.
 - b. The service was reduced because a portion of the relevant anatomy is absent (either congenitally, traumatically, or surgically).
2. Use modifier 53 when:
 - a. The service was discontinued (stopped mid-stream) because the patient experienced a life-threatening condition.
 - b. The procedure was not able to be completed because of anatomical difficulties (e.g., blockage, poor bowel prep), patient anxiety (which may require general anesthesia in a different setting), or equipment problems.
 - c. A repeat procedure is planned later to complete the remainder of the procedure.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
GI	=	Gastrointestinal
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
IUD	=	Intrauterine Device
MPFS MPFSD MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

Modifier Definitions:

Modifier	Modifier Description & Definition
53	<p>Discontinued Procedure: 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. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure.</p> <p>Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use.)</p>

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

CPT Modifier 53 was created in 1997 to distinguish between procedures which are reduced at the physician's discretion and procedures which are stopped mid-stream because the patient experienced a life-threatening condition.

- Procedures which are reduced at the physician's discretion are reported with modifier 52.
- Procedures which are terminated or discontinued due to a patient's life-threatening condition are reported with modifier 53.

CPT Assistant, December 1996 states:

"CPT Modifier -53 should be appended to a procedure code to report those circumstances when a patient experiences an unexpected response, (eg, arrhythmia or hypotensive/hypertensive crisis) causing the procedure to be terminated. This modifier differs from CPT modifier -52 (which describes a procedure that was reduced at the physician's discretion) because the patient's life-threatening condition precipitates the terminated procedure."

Appropriate Use

Modifier 53 may be used with surgical or diagnostic procedures and reported by physicians or other qualified health care professionals. Modifier 53 may not be reported by facilities.

Inappropriate Use

- Reporting more than one procedure code with modifier 53 attached.
- To report elective cancellation of a procedure.
- To report cancellation prior to anesthesia induction and/or surgical preparation in the operating suite.
- To report a laparoscopic procedure which is subsequently converted to an open procedure.
- When appended to Evaluation and Management procedure codes.
- May not be appended to time-based procedure codes (e.g., critical care, psychotherapy, therapeutic procedures)

“If 2 procedures only differ in that 1 is described as an “incomplete” procedure and the other as a “complete” procedure, the “incomplete” procedure is included in the “complete” procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.” (CMS¹⁴)

Cross References

- A. [“Modifier 52 – Reduced Services,”](#) Moda Health Reimbursement Policy Manual, RPM003.
- B. [“Modifier 22 – Increased Procedural Services.”](#) Moda Health Reimbursement Policy Manual, RPM007.
- C. [“Modifiers 73 & 74 - Discontinued Procedures For Facilities.”](#) Moda Health Reimbursement Policy Manual, RPM049.
- D. [“Modifier 50 – Bilateral Procedure.”](#) Moda Health Reimbursement Policy Manual, RPM057.

References & Resources

1. American Medical Association. “Appendix A – Modifiers.” *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. American Medical Association. “Modifiers”. *CPT Assistant*. Chicago: AMA Press, Spring 1991, p. 7.
3. American Medical Association. “Modifiers Used with Surgical Procedures”. *CPT Assistant*. Chicago: AMA Press, Fall 1992, p. 15.
4. American Medical Association. “Modifiers”. *CPT Assistant*. Chicago: AMA Press, November 1996, p. 19.
5. American Medical Association. “Review of the 1997 Modifier Changes”. *CPT Assistant*. Chicago: AMA Press, December 1996, p. 8.
6. American Medical Association. “Modifiers, Modifiers, Modifiers: A Comprehensive Review”. *CPT Assistant*. Chicago: AMA Press, May 1997, p. 1.
7. American Medical Association. “Modifiers”. *CPT Assistant*. Chicago: AMA Press, January 2000, p. 5.
8. American Medical Association. “Modifier Update-New and Revised Modifiers for Outpatient Use”. *CPT Assistant*. Chicago: AMA Press, May 2000, p. 1.
9. Grider, Deborah J. Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage. Chicago: AMA Press, 2004, pp. 109-114.
10. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 4 – Part B Hospital (Including OPPS), §20.6.4.

11. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 14 – Ambulatory Surgical Centers, §40.4.
12. American Medical Association. “Coding Consultation - Female Genital System, 58300, 58301 (Q&A).” *CPT Assistant*. Chicago: AMA Press, April 1998, p. 14.
13. Next Services. “Choosing between Modifier 53 and 52 (Gastroenterology example).” www.nextservices.com. Published: March 29, 2017; Last accessed: March 2, 2021. <https://www.nextservices.com/choosing-between-modifier-53-and-52-gastroenterology-example/#:~:text=By%20definition%2C%20modifier%2053%20is,52%20can%20sometimes%20be%20confusing>.
14. CMS. “More Extensive Procedure.” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § L.6.
15. ACOG. “Coding for the Contraceptive Implant and IUDs.” American College of Obstetricians and Gynecologists. May 9, 2018. Last accessed 12/21/2021. https://www.kdheks.gov/c-f/integration_toolkits/LARC/Coding_and_Billing.pdf.
16. CMS. “Payment Due to Unusual Circumstances (Modifiers “-22” and “-52”).” *Medicare Claims Processing Manual*, pub. 100-04, Chapter 12 - Physicians/Nonphysician Practitioners, § 20.4.6.
17. CMS. “Incomplete Colonoscopies.” *Medicare Claims Processing Manual*, pub. 100-04, Chapter 12 - Physicians/Nonphysician Practitioners, § 30.1.B.

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g., T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
5/8/2024	Annual/Clarification/Update: Section D.4: Added for clarification.
9/20/2023	Formatting/Update: Appendix added with copy of September 13, 2023 provider notification letter.
8/31/2023	Policy change/update: Change pricing from manual review to flat rate reimbursement. Approved by upper management & Provider Networking. Cross References: Hyperlinks added.

Date	Summary of Update
10/12/2022	Formatting/Update: Change to new header; includes Idaho. Acronym table: 1 entry added.
5/11/2022	Clarification/update. Added additional clarification & examples of incorrect use of modifier 53. Supporting quote added to Coding Guidelines section & References & Resources 4 entries added. Policy History: Added. Entries prior to 2022 omitted (in archive storage).
2/26/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
9/13/2007	Original Effective Date (with or without formal documentation). Policy based on CMS Pub. 100-04, ch. 12, § 20.4.6 & § 30.1.B. (CMS ^{19, 17})

Appendix

(This provider letter applies to all states except Texas. For a copy of the Texas letter, please contact our Customer Service Team.)

September 13, 2023



«Prov_Group_Name»
Attn: Billing/Office Manager
«PRAD_ADDR1» «PRAD_ADDR2»
<<City>>, <<State>> <<Zip>>

Dear Billing/Office Manager,

Effective for dates of service November 15, 2023 and following, procedure codes with modifier 52 appended for reduced services will be reimbursed at 50%. Procedure codes with modifier 53 appended will be reimbursed at 25%. Procedure codes with assigned Relative Value Units (RVU) for the modifier 53 combination will be paid per their assigned RVU. For dates of service prior to November 15, 2023, claims will continue to be manually priced on a case-by-case basis based on a review of the claim and/or medical records.

Clinical editing will be implemented to automate these changes. As Moda will no longer require medical records to determine reimbursement, the new process will both reduce the administrative burden to our providers and significantly improve the turnaround time for the processing and payment of these claims. The reimbursement policies below have been updated to reflect these changes:

- [“Modifier 52 – Reduced Services”](#) Moda Health Reimbursement Policy Manual, RPM003.
- [“Modifier 53 – Discontinued Procedure”](#) Moda Health Reimbursement Policy Manual, RPM018.

Questions?

We’re here to help. Just email medical@modahealth.com or call us toll-free at 877-605-3229.

Sincerely,

Moda Health Medical Provider Relations team