



Manual:	Reimbursement Policy		
Policy Title:	<b>Modifier 53 - Discontinued Procedure</b>		
Section:	Modifiers		
Subsection:	none		
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## Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid plans. This policy also applies to Summit Health plans for these lines of business.

## 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 Service<sup>13</sup>)  
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. (CMS<sup>12</sup>)

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 52 may not be used for supply items. 2) Defective implants or supplies are to be returned to the supplier for replacement or refund. 3) Related note (not included in this example): Dropped or 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 <sup>12</sup>) In these situations, the unsuccessful reinsertion (58300-53) will be reimbursed at 70% because it was not completed.  
Important Note: Since 58300-53-51 is a secondary procedure, that reduced amount is also subject to multiple procedure rules.
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. If there is no separate RVU listing for the procedure code with modifier 53 appended, the discontinued procedure will be manually priced.
  - a. Based on consistent claims-review experience, 58300-53 is reimbursed at 70% plus multiple procedure reductions (see above Exceptions, removal and reinsertion of IUD).
  - b. If the procedure was terminated shortly after anesthesia was induced and before much of the procedure was performed, we will allow 25-30% of the allowable amount for the unmodified code to cover reimbursement for the pre-operative RVU and a portion of the intraoperative RVU.
  - c. If the procedure was terminated at a later point in the process, the allowance is adjusted based on the percentage of the full service that has been performed and documented, as determined in the manual pricing review of the claim.

#### **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<sup>B</sup>)

#### **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 Defined

Acronym		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")
IUD	=	Intrauterine Device
MPFS MPFSD MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Groups (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
RVU	=	Relative Value Unit
UB	=	Uniform Bill

#### Modifier Definitions:

Modifier	Modifier Definition
53	<p><b>Discontinued Procedure:</b> 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><b>Note:</b> 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.</p> <p>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**

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 cancelation 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." (CMS<sup>14</sup>)

### **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](https://www.nextservices.com/choosing-between-modifier-53-and-52-gastroenterology-example/#:~:text=By%20definition%2C%20modifier%20is,52%20can%20sometimes%20be%20confusing). 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%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/cf/integration\\_toolkits/LARC/Coding\\_and\\_Billing.pdf](https://www.kdheks.gov/cf/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. Moda Health 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](https://www.modahealth.com/medical/policies_reimburse.shtml) \*\*\*\*\*

### Policy History

Date	Summary of Update
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 <sup>19, 17</sup> )