



Discontinued Procedures

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

This reimbursement policy is applicable to services documented using the 1500 Health Insurance Claim Form (CMS 1500) or its electronic equivalent, as well as any succeeding forms. This policy extends to all healthcare products and encompasses both network and non-network physicians and other qualified healthcare professionals. This includes, but is not limited to, non-network authorized practitioners and those under percent of charge contracts. The term 'Discontinued Procedure' denotes a surgical or diagnostic procedure delivered by a physician or other healthcare professional that falls short of the typical requirements outlined in the Current Procedural Terminology (CPT®) book. Discontinued Procedures should be indicated with the use of Modifier 53. It is inappropriate to apply Modifier 53 when a portion of the intended procedure has been completed, and a corresponding code exists to represent the completed segment of the intended procedure.

Reimbursement Guidelines

In specific situations, such as when there is a significant risk to the patient's well-being, a surgical or diagnostic procedure may be halted on the direction of the physician or other healthcare professional. In such cases, the procedure performed should be identified using its usual procedure code, accompanied by the addition of Modifier 53 (Discontinued Procedure). Modifier 53 indicates that the procedure was initiated but subsequently discontinued. This allows for the proper reporting of the Discontinued Procedure while preserving the essential service.

In accordance with the guidelines provided by the Centers for Medicare & Medicaid Services (CMS) and Current Procedural Terminology (CPT) coding standards, Modifier 53 should be applied exclusively to surgical codes or medical diagnostic codes. It should not be used in the following situations:

- Evaluation and management (E/M) services.
- Planned cancellation of a procedure before the patient undergoes anesthesia induction and/or surgical preparation in the operating suite.
- Instances where a laparoscopic or endoscopic procedure is converted into an open procedure, or when a procedure undergoes a significant change or conversion into a more extensive procedure.

Molina Healthcare's standard reimbursement for Discontinued Procedures with Modifier 53 is set at 33% of the Allowable Amount for the primary unmodified procedure. Multiple procedure reductions will still be applicable. For procedures that are partially reduced or eliminated at the physician's discretion, please refer to Molina Healthcare's Reduced Services and Discontinued Procedures Policy.

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Allowable Amount	The dollar amounts eligible for reimbursement to the physician or health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of allowable amounts.
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.

State Exceptions

State	Exception
FL	FL Medicaid reimbursement for modifier 53 is 50%
KY	KY Medicaid is exempt from the Discontinued Procedure Policy. The 53 modifier is not reimbursable.
NY	NY Medicaid does not recognize modifier 53
WA	WA Medicaid reimbursement for modifier 53 is 50%
AZ	AZ is Exempt from the Discontinued Procedure Policy
MI	MI Medicaid reimbursement for modifier 53 is 50% excluding G0105-53, G0121-53, 44388-53, and 45378-53

Documentation History

Type	Date	Action
Initial Creation Date	09/01/2023	New Policy
Revised Date	12/16/2024	Updated Template
Revised Date	04/30/2025	Updated State Exceptions
Revised Date	08/04/2025	Updated Template

References

References This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts
- American Medical Association, Current Procedural Terminology (CPT®) Professional

Reference	Link

***CODING DISCLAIMER.** Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.