# Reduced Services and Discontinued Procedures (Professional and Facility)

## 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 applies to all healthcare services billed on UB04 forms (CMS 1450) and CMS 1500 forms. The reimbursement policy is developed by considering various factors such as coding methodology, industry-standard reimbursement criteria, regulatory mandates, benefits design, and other relevant considerations.

According to the guidelines in the Current Procedural Terminology (CPT®) book, a healthcare service or procedure may be partially reduced or eliminated at the discretion of the physician or other qualified healthcare professional under specific circumstances. In such cases, the service provided should be identified using its standard procedure code, with the addition of Modifier 52 (Reduced Services) to indicate that the service has been reduced. This allows for the reporting of Reduced Services without altering the identification of the basic service.

Modifier 52 is mainly used to indicate the partial reduction or discontinuation of services such as radiology procedures and other procedures that do not require anesthesia. However, it is important not to use Modifier 52 if a portion of the intended procedure has been completed and a corresponding code exists that represents the completed portion of the intended procedure.

## Reimbursement Guidelines

**Reduced Services**

There are no established industry standards for reimbursement of claims billed with Modifier 52 by the Centers for Medicare and Medicaid Services (CMS) or other professional organizations. At Molina Healthcare, our standard for reimbursing claims with Modifier 52 is set at 50% of the Allowable Amount for the unmodified procedure.

It is important to note that Modifier 52 should not be utilized to report the elective cancellation of a procedure prior to anesthesia induction, intravenous (IV) conscious sedation, or surgical preparation in the operating suite. Additionally, it is not appropriate to use Modifier 52 in conjunction with an evaluation and management (E/M) service.

**Discontinued Procedures**

The term 'Discontinued Procedure' refers to a surgical or diagnostic procedure delivered by a physician or other healthcare professional, which falls short of the standard requirements outlined in the Current Procedural Terminology (CPT®) book.

- **Professional Claims**: Discontinued Procedures are indicated using Modifier 53 (Discontinued Procedure). Modifier 53 signifies that a physician chose to terminate a surgical or diagnostic procedure due to extenuating circumstances that posed a risk to the patient's well-being. It's important to note that Modifier 53 should not be applied if a portion of the intended procedure was completed and there exists a corresponding code for that completed portion. It's worth mentioning that there are no established industry standards for the reimbursement of claims using Modifier 53, whether from the Centers for Medicare and Medicaid Services (CMS) or other professional organizations. At Molina Healthcare, our standard reimbursement rate for claims involving Modifier 53 is set at 33% of the Allowable Amount for the unmodified

procedure. Please keep in mind that Modifier 53 is not applicable for facility billing and cannot be used in conjunction with E&M (Evaluation & Management) or time-based codes .

- **Facility Claims**: In a facility setting, Discontinued Procedures are reported using either Modifier 73 or Modifier 74. If the procedure was discontinued before the administration of anesthesia, you should append Modifier 73. In such cases, reimbursement will be at 50% of the Allowable Amount for the unmodified procedure. However, if the procedure was discontinued after the administration of anesthesia, you should append Modifier 74, and reimbursement will be at 100% of the Allowable Amount for the unmodified procedure. Please note that Modifiers 73 and 74 are exclusively utilized to signify Discontinued Procedures in cases where anesthesia is either planned or provided. They are not applicable in a professional setting.

## Supplemental Information

**Definitions**

| Term | Definitions |
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| 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 | Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For the percentage of charge or discount contracts, the Allowable Amount is determined as the amount billed, less the discount. |
| 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. For facility claims, discontinued procedures may be reported by appending Modifier 73 or Modifier 74. |
| Modifier 52 | Reduced Services |
| Modifier 53 | Discontinued Procedure |
| Modifier 73 | Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia |
| Modifier 74 | Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia |

## State Exceptions

| State | Exception |
|---|---|
| AZ | AZ Is Exempt from this Molina Policy. |
| CA | Requires "By Report" documentation. |
| CT | Outpatient facility claims are non-payable when modifiers 52, 73 or 74 are used on a claim. No information on modifier 53. No information on professional claims. |
| FL | For professional claims, FL Medicaid reimbursement for modifiers 52 and 53 is 50%. |

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| | Although Modifiers 73 and 74 are not explictly mentioned, Florida Medicaid states, "Florida Medicaid covers services performed in an ASC that are terminated before the service or procedure is complete when the recipient's well-being is threatened by medical complications." |
| ID | Modifier 52 is referenced in the Idaho Medicaid Provider Manual, via Information Release MA16-09; however MA16-09 was unable to be located. For Modifier 53, allowed only for professional claims (not permitted on outpatient hospital or ASC claims). When used, reimbursement is reduced by 25% (i.e., provider receives 75% of the allowed amount). No information on modifiers 73 or 74. |
| IL | Modifiers 53, 73 and 74 are not payable. Modifier 52 requires manual (hand) pricing. An attachment or explanation must be submitted describing why the service was reduced. |
| IA | Modifier 52: reimbursement at 50% of the fee schedule amount. Modifier 53: reimbursement based on review of submitted documentation (no flat percent shown; requires manual adjudication). Modifier 73: reimbursement is 50% of the ASC-level fee schedule amount. Modifier 74 – no information. |
| KY | KY Medicaid is exempt from the Discontinued Procedure Policy. 53 modifier is not reimbursable. |
| MA | Modifiers 52, 73, and 74 are acceptable for billing in the Fee-for-Service acute outpatient hospital setting. No information on modifier 53. |
| MI | MI Medicaid reimbursement for modifier 53 is 50% excluding G0105-53, G0121-53, 44388-53, and 45378-53. |
| NV | Nevada Medicaid recognizes modifier 53, as indicated in the provider fee schedule. Reimbursement methodology for modifier 53 isn't detailed. |
| NY | NY Medicaid does not recognize modifier 53. |
| OH | Professional claims: OH Medicaid does not recognize modifiers 52 or 53. Outpatient Hospital: Modifier 52 - Payment is usually reduced proportionally (not the full fee schedule rate). The facility is expected to append 52 to show less work was done. Modifier 73 - Used when a procedure was discontinued before anesthesia was administered. Payment is typically a percentage of the full procedure rate (often 50% for hospitals/ASCs under Medicare rules). Ambulatory Surgery Center (ASC) facility claims - ODM lists modifier 52 and modifier 73 as payment-affecting modifiers on ASC facility claims. |
| SC | Professional claims: modifiers 52 and 53 are recognized. Facility claims: modifiers 52, 53, 73 and 74 are recognized. |
| UT | Modifier 52 - Professional & Facility - recognized; reimbursed at 50%. Modifier 53 - Professional & Facility - recognized; reimbursed at 50%. Modifier 73 - Facility (Outpatient/ASC) - recognized; reimbursed at 50%. Modifier 74 - Facility (Outpatient/ASC) - recognized; reimbursed at 50%. |
| WA | WA Medicaid reimbursement for modifier 53 is 50%. |

## Documentation History

| Type | Date | Action |
|---|---|---|
| Initial Creation Date | 05/01/2023 | New Policy |
| Revised Date | 12/12/2024 | Updated Template |
| Revised Date | 08/05/2025 | Updated Template |

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| Revised Date | 09/10/2025 | Changed Initial Creation Date from 07/11/2023 to 05/01/2023; refreshed broken hyperlinks; researched and documented state exceptions. |

## References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

| Reference | Link |
|---|---|
| CA | MODIFIERS: APPROVED LIST |
| CT | CT PROVIDER MANUAL |
| FL | FL FEE SCHEDULE NOTES |
| FL | FL MEDICAID SERVICES COVERAGE POLICY |
| ID | IDAHO MEDICAID PROVIDER HANDBOOK |
| IA | PROCEDURE CODE MODIFIERS |
| MA | ACUTE OP HOSPITALS |
| NV | FEE-SCHEDULE |
| OH | MODIFIERS RECOGNIZED BY ODM |
| SC | sERVICES PROVIDER MANUAL |
| UT | UTAH MEDICAID PROVIDER MANUAL |
| WA | PROVIDER BILLING GUIDES |

*__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.