Reimbursement Policy for 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 plan document 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.

Supplemental Information

Definitions

Term	Definition
CMS	Center for Medicare and Medicaid
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
Florida	FL Medicaid reimbursement for modifier 53 is 50%
Kentucky	KY Medicaid is exempt from the Discontinued Procedure Policy. The 53 modifier is not. reimbursable.
New York	NY Medicaid does not recognize modifier 53.
Washington	WA Medicaid reimbursement for modifier 53 is 50%
AZ	AZ is Exempt from the Discontinued Procedure Policy

Documentation History

Type	Date	Action
Published	09/01/2023	
Revised Date		

References

This policy was developed using.

- State Contracts
- Individual state Medicaid regulations, manuals & fee schedules
- American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS (Healthcare Common Procedure Coding System) Release and
- Code Sets