PI Payment Policy 59 Discontinued Procedure Reimbursement Policy, Professional

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.

Policy

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (CMS 1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and nonnetwork physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Overview

The term "Discontinued Procedure" designates a surgical or diagnostic procedure provided by a physician or other health care professional that was less than usually required for the procedure as defined in the Current Procedural Terminology (CPT®) book. Discontinued Procedures are reported by appending Modifier 53. It is not appropriate to use Modifier 53 if a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.

Reimbursement Guidelines

Under certain circumstances such as a serious risk to the patient's well-being, a surgical or diagnostic procedure is terminated at the physician or other health care professional's direction. Under these circumstances the procedure provided should be identified by its usual procedure code and the addition of Modifier 53 (Discontinued Procedure) signifying that the procedure was started but discontinued. This provides a way to report the Discontinued Procedure, leaving the basic service intact.
According to the Centers for Medicare & Medicaid Services (CMS) and CPT (Current Procedural Terminology) coding guidelines, Modifier 53 should be used with surgical codes or medical diagnostic codes. Modifier 53 should not be used with:

- Evaluation and management (E/M) services
- Elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.
- When a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure.

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

Supplemental Information

State Expectations	
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 is exempt from the Discontinued Procedure Policy.

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.

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

Policy History	
04/06/2023	Drafted