Discontinued Procedure (Modifier 53)

Reimbursement Policy ID: RPC.0019.7700

Recent review date: 11/2022

Next review date: 11/2023

AmeriHealth Caritas Ohio claim payment policies and the resulting edits are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state regulatory agencies, and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT©), the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10); and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify, or in some cases supersede medical/claim payment policy. These factors may include but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

Policy Overview

This policy describes requirements for billing of discontinued procedures by providers contracted with AmeriHealth Caritas Ohio.

AmeriHealth Caritas Ohio recognizes modifier 53 for discontinued procedures, consistent with Current Procedural Terminology (CPT) and American Medical Association (AMA) official guidance. Providers must submit clean claims, using appropriate CPT/HCPCS codes and their modifiers, consistent with Ohio Department of Medicaid (ODM) billing and other guidelines.

Exceptions

N/A

Coding

Claims for diagnostic or surgical procedures that were discontinued in inpatient settings after the induction of anesthesia due to extenuating circumstances, or circumstances that threaten the well-being of the patient (e.g., arrhythmia or hypotensive/hypertensive crisis), are reimbursable when the CPT/HCPCS procedure code is reported with modifier 53. A reduction in payment may apply.

AmeriHealth Caritas Ohio will deny claims where modifier 53 is reported for procedures that were discontinued in outpatient settings, before the induction of anesthesia, and/or electively. Claims for Evaluation and Management (E/M) services with modifier 53 appended will be denied. Claims for time-based procedures with modifier 53 appended will also be denied.

Consistent with the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) policy, modifier 53 should not be appended to multiple procedures, or to a procedure with multiple units, for the same date of service by the same provider. A physician or other qualified health care professional from the same group practice under the same specialty under and same Tax Identification Number (TIN) is considered the same provider.

When a procedure was completed after multiple attempts on the same date of service, only one (1) instance of the procedure is reimbursable, without modifier 53.
When multiple procedures were planned for the same date of service:

- If any procedures were completed, only those procedures are reimbursable, without modifier 53.
- If no procedures were completed, only the first procedure is reimbursable as a discontinued procedure, with modifier 53.

Claims with modifier 53 inappropriately appended will be denied.

Clinical documentation must state the plan for the procedure, the reason for which the procedure was discontinued, and the portion/percentage of the procedure that was completed. Appropriate diagnosis coding may also indicate the reason for which the procedure was discontinued.

Please refer to CPT/HCPS manuals for complete descriptions of procedures and modifiers, to the ICD-10-CM manual for guidelines and descriptions of diagnoses and other conditions, and to ODM billing resources for fee schedules and billing guidelines.

Definitions

53-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 wellbeing 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. Note: 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. 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 wellbeing of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

Same Provider
A physician or other qualified health care professional from the same group practice under the same specialty under and same Tax Identification Number (TIN) is considered the same provider.

Applicable Claim Types

Line of Business	Facility	Professional
Medicare	**No**	**No**
Medicaid	**No**	**Yes**
ACA Exchange	**No**	**No**

Edit Sources

I. *Current Procedural Terminology* (CPT®), *Healthcare Common Procedure Coding System* (HCPCS®), *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Clinical Modification* (ICD-10-CM), and associated publications and services.
II. The Centers for Medicare and Medicaid Services (CMS) National Correct Coding Policy (NCCI): https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci
III. Ohio Department of Medicaid (ODM) fee schedules and billing guidelines: https://medicaid.ohio.gov/resources-for-providers/billing/billing

Attachments

N/A

Policy History

11/15/2022	AmeriHealth Caritas Implementation
11/15/2022	Reimbursement Policy Committee Approval