Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

Reimbursement Guidelines

Modifier 53 is considered valid on a maximum of one procedure code per date of service.

When multiple procedures were planned:

- It is never appropriate to report more than one procedure code with modifier 53.
- When none of the planned procedures is completed, then the first planned procedure is reported with modifier 53. The other planned procedure(s) are not reported.
  - Modifier 50 and modifier 53 may not be reported together on the same procedure code.
  - When a bilateral procedure is planned and discontinued before either side is completed, only a unilateral procedure code may be reported with modifier 53.
- If one or more of the procedures planned is completed, the completed procedures are reported as usual. The other procedure(s) that are discontinued or not completed are not reported and are not eligible for separate reimbursement.
  - Exceptions:
    - Upper GI and Lower GI procedures, same day:
      - The only time it is appropriate to report a discontinued procedure with modifier 53 in combination with completed procedure codes is when the completed procedures are upper GI endoscopy procedures and the single, discontinued procedure is a lower GI endoscopy, or vice versa. 
        (Exceptions continued on next page)
      - However, it is still not appropriate to report a completed lower GI procedure code in combination with a discontinued lower GI procedure code. In that case, only the completed lower GI code may be reported.
Removal and reinsertion of IUD:
If an IUD is successfully removed, and the reinsertion of the new IUD is not successful, both procedures may be reported. (AMA) In these situations, the unsuccessful reinsertion (58300-53) will be reimbursed at 70% because it was not completed.

Important Note: Since 58300-53-51 is a secondary procedure, that reduced amount is also subject to multiple procedure rules.

Providers will be reimbursed for one discontinued procedure with modifier 53. Additional discontinued procedures for the same date of service are not eligible for reimbursement.

Documentation Requirements

The medical record must include documentation that the procedure was started, why the procedure was discontinued, and the percentage of the procedure that was performed. This supporting documentation must be available for review upon request.

Determining the reduction for modifier 53

1. Any procedure code that has a separate RVU amount listed on the CMS Physician Fee Schedule when modifier 53 is appended (e.g. 45378-53, G0105-53, G0121-53) will be priced by Moda Health based upon a comparison of the RVU for the unmodified code to the RVU for the modifier 53 listing.

   For example:
   45378-53 is used to report a diagnostic colonoscopy (45378) during which the provider was unable to advance the instrument to the cecum or colon-small intestine anastomosis due to unforeseen circumstances. The CMS Physician Fee Schedule lists a separate RVU/pricing for 45378-53, which is approximately 50% of the RVU for 45378 (unmodified). Accordingly, Moda Health will price 45378-53 at 50% of the allowable amount for the unmodified procedure.

2. If there is no separate RVU listing for the procedure code with modifier 53 appended, the discontinued procedure will be manually priced.
   a. Based on consistent claims-review experience, 58300-53 is reimbursed at 70% plus multiple procedure reductions (see above Exceptions, Removal and reinsertion of IUD).
   b. If the procedure was terminated shortly after anesthesia was induced and before much of the procedure was performed, Moda Health will allow 25-30% of the allowable amount for the unmodified code to cover reimbursement for the pre-operative RVU and a portion of the intraoperative RVU.
   c. If the procedure was terminated at a later point in the process, the allowance is adjusted based on the percentage of the full service that has been performed and documented, as determined in the manual pricing review of the claim.
Use of Modifier 53 on Facility Claims

Modifier 53 is used to indicate discontinuation of physician & professional services only and is not approved for use by outpatient hospital services or ASCs.

Procedures reported by ASCs or outpatient hospitals with modifier 53 appended will be denied. This is an invalid use of modifier 53. See RPM049, “Modifiers 73 & 74 - Discontinued Procedures For Facilities.” (B)

Codes and Definitions

Modifier 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 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.

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

Coding Guidelines

CPT Modifier 53 was created in 1997 to distinguish between procedures which are reduced at the physician’s discretion and procedures which are stopped mid-stream because the patient experienced a life-threatening condition.

- Procedures which are reduced at the physician’s discretion are reported with modifier 52.
- Procedures which are terminated or discontinued due to a patient's life-threatening condition are reported with modifier 53.

CPT Assistant, December 1996 states:

“CPT Modifier -53 should be appended to a procedure code to report those circumstances when a patient experiences an unexpected response, (eg, arrhythmia or hypotensive/hypertensive crisis) causing the procedure to be terminated. This modifier differs from CPT modifier -52 (which describes a procedure that was reduced at the physician' discretion) because the patient's life-threatening condition precipitates the terminated procedure.”
Appropriate Use

Modifier 53 may be used with surgical or diagnostic procedures and reported by physicians or other qualified health care professionals. Modifier 53 may not be reported by facilities.

Inappropriate Use

- Reporting more than one procedure code with modifier 53 attached.
- To report elective cancelation of a procedure.
- To report cancellation prior to anesthesia induction and/or surgical preparation in the operating suite.
- To report a laparoscopic procedure which is subsequently converted to an open procedure.
- When appended to Evaluation and Management procedure codes.
- May not be appended to time-based procedure codes (e.g. critical care, psychotherapy, therapeutic procedures)

Cross References


References & Resources


Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.
Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

**IMPORTANT STATEMENT**

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.