Discontinued Procedures (Modifier 53)

Reimbursement Policy ID: RPC.0019.72KF

Recent review date: 11/2023

Next review date: 11/2024

Keystone First Community HealthChoices reimbursement policies and their 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 and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First Community Health Choices may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy describes requirements for billing of discontinued procedures by providers contracted with Keystone First Community HealthChoices.

Keystone First Community HealthChoices 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 Pennsylvania Department of Human Services (PADHS) and other guidelines.

Exceptions

N/A

Reimbursement Guidelines

Keystone First Community HealthChoices 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 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, for Pennsylvania Department of Human Services (PADHS) fee schedules and billing guidelines.

Definitions

53-discontinued procedure
May be used only when a physician or other qualified health care professional elects to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well-being of the patient.

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.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. 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
V. Pennsylvania Department of Human Services (PADHS) and billing guidelines:

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
11/2023	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First Community HealthChoices from Policy History section
01/2023	Template revised. • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section