LifeWise
Health Plan of Washington

Payment Policy

cmi_051719

Title	**Modifier 53 – Discontinued Procedure**		
Number	**CP.PP.236.v2.9**		
Last Approval Date	02/05/24	**Original Effective Date**	01/01/05
Cross Reference	• *Modifier SG – Ambulatory Surgery Center (ASC) facility services* • *Modifier 73 – Discontinued Outpatient Hospital/Ambulatory Surgery Center Procedure Prior to Administration of Anesthesia* • *Modifier 74 – Discontinued Outpatient Hospital/Ambulatory Surgery Center Procedure After Administration of Anesthesia*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with Modifier 53 that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products. Medicare Advantage products are not subject to this policy.
Policy	The Plan recognizes Modifier 53-*Discontinued Procedure* when appended to a **professional service** to indicate that a surgical or diagnostic medical procedure was either terminated or was discontinued **after** induction of anesthesia due to extenuating circumstances beyond the control of the physician, the other qualified healthcare professional, or the patient. Medical records for the member must document why the procedure was discontinued and at what point in the surgery the procedure was discontinued. Modifier 53 is not appropriate to be appended to the following categories: • an elective cancellation of a procedure prior to the administration of anesthesia or surgical preparation in the operating suite • Evaluation and Management (E&M) codes • unlisted procedure codes • time-based procedure codes • when there is a more appropriate/lesser procedure code that is available to describe the portion of the procedure that was completed, or • to any ASC facility or Outpatient facility service For discontinued ASC and outpatient facility services, modifiers 73- *Discontinued Outpatient Hospital/Ambulatory Surgery Center Procedure Prior to Administration of Anesthesia* or 74- *Discontinued Outpatient Hospital/Ambulatory Surgery Center Procedure After Administration of Anesthesia* are appended to the discontinued procedure code. Reimbursement for procedures appended with Modifier 53 will be adjusted to reflect 33% of the provider's applicable Fee Schedule allowed amount.

Violations of Policy	Violations of this policy by any party that enters a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None
References	• American Medical Association's Current Procedural Terminology (AMA/CPT) codebook • Centers for Medicare and Medicaid Services (CMS)

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	02/05/24; 03/13/23; 04/08/22; 04/16/21; 04/30/20; 05/24/19; 06/05/18; 08/11/17; 09/14/16; 11/15/15; 11/23/14; 01/13/13; 01/26/12; 01/27/11; 02/12/10; 03/24/09; 06/16/08; 05/13/07; 04/11/06; 02/28/06; 08/29/05; 07/30/04	
Version History	06/05/18	Annual review; no changes
	05/24/19	Annual review; no changes
	04/30/20	Annual review; no changes
	04/16/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms.
	04/08/22	• Added three Payment Policy references in the Cross Reference section • In the Policy section, added examples of when Modifier 53 is not appropriate to append to a service • Added a new paragraph in the Policy section to indicate that Modifiers 73 and 74 are not appropriate to append to a professional service, only to an ASC facility service
	03/13/23	Clarified the Policy statement that the use of modifier 53 is valid for professional services only and that modifiers 73 and 74 are appropriate for discontinued ASC and Outpatient facility services.
	02/05/24	In the Policy section, in paragraph three, added the third and fifth bullets.

This policy was published on February 8, 2024