Modifier 53 – Discontinued Procedure

Last Updated: 4/9/2025 **Last Reviewed: 4/9/2025** **Originally Effective: 9/13/2007**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM018**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** Details below

Reimbursement Guidelines

A. Modifier 53 is Not Valid or Appropriate When:

1. Modifier 53 is not valid when another (lesser) code is available to describe the portion of the discontinued service which was completed.

   Example:

   A colonoscopy was planned. Unable to reach the cecum to qualify for colonoscopy code but did reach the sigmoid colon and a polyp was removed within the areas reached.

   - 45385 may not be reported with modifier 53.
   - A sigmoidoscopy procedure code needs to be reported instead.[13] Choose the correct procedure code based upon the technique used to remove the polyp:
     - 45333 (Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps)
     - 45338 (Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique)

2. Modifier 53 is not appropriate to use when multiple attempts were required to successfully accomplish the procedure.
   a. All attempts to accomplish a procedure during the same patient encounter or operative session are included in the procedure code for the successful procedure.[12]
   b. Examples (not all inclusive):
      i. IUD placement.
         1) Procedure note describes: "The first two IUDs were placed without difficulty but failed to deploy and were expelled or removed. A different lot number and different size IUD was selected, and the third IUD was placed and deployed normally without issue."
         2) Claim submitted:

Codes & Units submitted	Comments
58300 x 1 unit	Successful IUD placement. Reimbursement for this line includes all attempts required in this session for a successful IUD placement.
J7301 x 1 unit	Supply for successfully placed IUD.
58300-53 x 2 units	Incorrect use of modifier 53. Reimbursement for unsuccessful attempts is included in the allowance for the successful procedure.
J7301-53 x 2 units	Incorrect use of modifier 53. 1) Modifier 53 may not be used for supply items. 2) See below for additional notes on IUDs.

3) Additional notes about IUD supply itself:
    1. If an IUD is successfully implanted, no more than one unit of an IUD may be billed.
    2. If the procedure does not result in a successful IUD placement in the patient, the IUD(s) used in the attempt(s) (e.g., J7301) may not be billed on the claim.
        a. Defective implants or supplies are to be returned to the supplier for replacement or refund.
        b. Any dropped or otherwise contaminated implants or supplies may not be reported on the claim. These are a practice expense or cost of doing business and are not eligible for reimbursement.

ii. Placement of esophageal stent (e.g., 43212).
iii. Placement of biliary duct or pancreatic duct stent (e.g., 43274-43276).
iv. Placement of ureteral stent (e.g., 50605, 50693-50695, 50947, 51045, etc.).
v. Placement of intracoronary stent(s) (e.g., 92928-92944).

B. Quantity Limits for Discontinued Procedures

1. Modifier 53 is considered valid on a maximum of one procedure code per date of service.
2. When multiple procedures were planned:
    a. It is never appropriate to report more than one procedure code with modifier 53.
    b. 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.
        i. Modifier 50 and modifier 53 may not be reported together on the same procedure code.
        ii. When a bilateral procedure is planned and discontinued before either side is completed, only a unilateral procedure code may be reported with modifier 53.
    c. 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:
        i. Upper GI and Lower GI procedures, same day:
            1) 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.
            2) 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.
        ii. 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.[12]
        Important Note: Since 58300-53-51 is a secondary procedure, that reduced amount is also subject to multiple procedure rules.
        See also information for coding and reimbursement of unsuccessful IUD placement.
3. 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.

C. 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 and provided for review upon request.

D. 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 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, 45378-53 will be priced at 50% of the allowable amount for the unmodified procedure.

2. Effective for date of service November 15, 2023 and following, if there is no separate RVU listing for the procedure code with modifier 53 appended, the discontinued procedure will be reimbursed at 25% of the usual allowable fee.

3. Effective for dates of service November 14, 2023 and prior, if there is no separate RVU listing for the procedure code with modifier 53 appended, the discontinued procedure will be manually priced, based upon the amount of the procedure work completed. Medical records may need to be reviewed to determine the reduction for pricing.

4. Other Pricing Adjustments Affect Final Line Item Allowable
   Please Note: When modifier 53 discontinued services fee reductions apply, other pricing adjustments may also apply before the final allowable amount for each line item is determined. For example, multiple procedure adjustments, bilateral adjustments, assistant surgeon adjustments, co-surgery adjustments, related within global adjustments, etc.

E. Use of Modifier 53 on Facility Claims

1. Modifier 53 is used to indicate discontinuation of physician & professional services only and is not approved for use by outpatient hospital services or ASCs.
2. 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]

F. Selecting Between Modifier 52 and Modifier 53

1. Use modifier 52 when:
   a. The service was reduced at the physician's discretion.
   b. The service was reduced because a portion of the relevant anatomy is absent (either congenitally, traumatically, or surgically).

2. Use modifier 53 when:
   a. The service was discontinued (stopped mid-stream) because the patient experienced a life-threatening condition.
   b. The procedure was not able to be completed because of anatomical difficulties (e.g., blockage, poor bowel prep), patient anxiety (which may require general anesthesia in a different setting), or equipment problems.
   c. A repeat procedure is planned later to complete the remainder of the procedure.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
ASC	Ambulatory Surgery Center
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E/M E&M E & M	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
GI	Gastrointestinal
IUD	Intrauterine Device
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)

Modifier Definitions

Modifier	Modifier Description & Definition
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.)

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Modifier 52 – Reduced Services," Moda Health Reimbursement Policy Manual, RPM003.
C. "Modifier 22 – Increased Procedural Services." Moda Health Reimbursement Policy Manual, RPM007.
D. "Modifiers 73 & 74 - Discontinued Procedures For Facilities." Moda Health Reimbursement Policy Manual, RPM049.
E. "Modifier 50 – Bilateral Procedure." Moda Health Reimbursement Policy Manual, RPM057.

Resources

1. American Medical Association. "Appendix A – Modifiers." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, Spring 1991, p. 7.
3. American Medical Association. "Modifiers Used with Surgical Procedures". *CPT Assistant*. Chicago: AMA Press, Fall 1992, p. 15.
4. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, November 1996, p. 19.

5. American Medical Association. “Review of the 1997 Modifier Changes”. *CPT Assistant*. Chicago: AMA Press, December 1996, p. 8.
6. American Medical Association. “Modifiers, Modifiers, Modifiers: A Comprehensive Review”. *CPT Assistant*. Chicago: AMA Press, May 1997, p. 1.
7. American Medical Association. “Modifiers”. *CPT Assistant*. Chicago: AMA Press, January 2000, p. 5.
8. American Medical Association. “Modifier Update-New and Revised Modifiers for Outpatient Use”. *CPT Assistant*. Chicago: AMA Press, May 2000, p. 1.
9. Grider, Deborah J. Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage. Chicago: AMA Press, 2004, pp. 109-114.
10. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 4 – Part B Hospital (Including OPPS), §20.6.4.
11. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 14 – Ambulatory Surgical Centers, §40.4.
12. American Medical Association. “Coding Consultation - Female Genital System, 58300, 58301 (Q&A).” *CPT Assistant*. Chicago: AMA Press, April 1998, p. 14.
13. Next Services. “Choosing between Modifier 53 and 52 (Gastroenterology example).” www.nextservices.com. Published: March 29, 2017; Last accessed: March 2, 2021. https://www.nextservices.com/choosing-between-modifier-53-and-52-gastroenterology-example/#:~:text=By%20definition%2C%20modifier%2053%20is,52%20can%20sometimes%20be%20confusing.
14. CMS. “More Extensive Procedure.” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § L.6.
15. ACOG. “Coding for the Contraceptive Implant and IUDs.” American College of Obstetricians and Gynecologists. May 9, 2018. Last accessed 12/21/2021. https://www.kdheks.gov/c-f/integration_toolkits/LARC/Coding_and_Billing.pdf .
16. CMS. “Payment Due to Unusual Circumstances (Modifiers “-22” and “-52”).” Medicare Claims Processing Manual, pub. 100-04, Chapter 12 - Physicians/Nonphysician Practitioners, § 20.4.6.
17. CMS. “Incomplete Colonoscopies.” Medicare Claims Processing Manual, pub. 100-04, Chapter 12 - Physicians/Nonphysician Practitioners, § 30.1.B.

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
4/9/2025	Acronyms & Related Policies updated. Formatting updates. No policy changes.
5/8/2024	Clarified other pricing adjustments may apply to modifier 53 line items.
9/20/2023	Appendix added with copy of September 13, 2023 provider notification letter.
8/31/2023	Pricing changing from manual review to flat rate reimbursement. Approved by upper management & Provider Networking. Formatting updates.
10/12/2022	Idaho added to Scope. Acronyms updated. No policy changes.
5/11/2022	Clarified incorrect use of modifier 53, examples included. Resources updated. Policy History: added. Entries prior to 2022 omitted (in archive storage).
2/26/2013	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
9/13/2007	Original Effective Date (with or without formal documentation). Policy based on CMS Pub. 100-04, ch. 12, § 20.4.6 & § 30.1.B. [19, 17]