Summary
This policy defines reimbursement for procedure codes appended with modifier 53, Discontinued Procedure.

Policy Statement
Under certain circumstances, a surgical or diagnostic procedure is terminated at the physician or other health care professional’s direction. Under these circumstances the procedure provided should be identified by its usual procedure code and the addition of modifier 53 (discontinued procedure) signifying that the procedure was started but discontinued. This provides a means of reporting the discontinued procedure, leaving the identification of the basic service intact.

According to the Centers for Medicare & Medicaid Services (CMS) and Current Procedure Terminology (CPT®) coding guidelines, modifier 53 should be used with surgical codes or medical diagnostic codes.

Medica’s reimbursement for services appended with modifier 53 is 50% of the allowable amount for the unmodified procedure for all eligible codes.

Modifier 53 should not be used with:
- Evaluation and management (E/M) services
- Cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite
- When a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure

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 physician for the discontinued procedure.

Resources
- Centers for Medicare and Medicaid Services (CMS)
- Healthcare Common Procedure Coding System (HCPCS)

Effective Date
01/01/1997
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