<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Once in a Lifetime Procedures</th>
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<tbody>
<tr>
<td><strong>Summary</strong></td>
<td>This policy limits the frequency of reimbursement for certain identified procedures to once in the patient’s lifetime. Once in a Lifetime Procedures, by the nature of their description, can be performed only once in a patient’s lifetime.</td>
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<td><strong>Policy Statement</strong></td>
<td>In general, Once in a Lifetime Procedures involve the removal of an organ in the body. Example: A patient only has one appendix, therefore an appendectomy can be performed only once in the patient’s lifetime. Once in a Lifetime Procedures are not limited to a single Current Procedural Terminology (CPT®) code, but may be represented by Code Families, which are a group of CPT codes that describe the same or similar type of service. Medica provides reimbursement for only one procedure from a designated Code Family during a patient’s lifetime. If a Once in a Lifetime Procedure is reported on separate claims with different dates of service, the claim will be paid for only one date of service. Claims for other dates of service will be denied unless one of the following modifiers has been appended to the Once in a Lifetime Procedure code: 53 – Discontinued Procedure 55 – Postoperative Management Only 56 – Preoperative Management Only 58 – Staged or Related Procedure or Service by the Same Physician During the Postoperative Period</td>
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| **Definitions**  | **Modifier 53 Discontinued Procedure**  
Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the wellbeing 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. **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 wellbeing of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use). |
**Modifier 55 Postoperative Management Only**
When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

**Modifier 56 Preoperative Management Only**
When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

**Modifier 58 Staged or related procedure or services by the same physician during the postoperative period**
The physician may need to indicate that the performance of a procedure or service during the postoperative period was:
- a) planned or anticipated (staged)
- b) more extensive than the original procedure
- c) for therapy following a diagnostic surgical procedure

**Code Lists**  
[Once in a Lifetime Procedures Code List](#)

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

**Effective Date**  
11/14/2010

**Revision Updates**  
- 04/02/2019  Code list update
- 01/01/2018  Code list update
- 07/21/2016  Annual policy review
- 12/11/2014  Annual policy review