Coding Policy

Modifiers -52 and -53: Reduced or Discontinued Procedures (Professional Charges)

CODING POLICY NUMBER: 57

Effective Date: 1/1/2024

Last Review Date: 1/2024

Next Annual Review: 2025

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies"). **The full Company portfolio of current coding policies is available online and can be accessed here.**

POLICY APPLICATION

☒ Providence Health Plan Participating Providers ☒ Non-Participating Practitioners

☒ Commercial ☒ Medicaid/Oregon Health Plan ☒ Medicare

POLICY STATEMENT

I. Modifier -52 is used to report "reduced services."

II. Modifier -53 is used to report "discontinued procedure."

(For outpatient/ASC facility charges, see Payment Policy 39.0.)

PROCEDURE

GENERAL

Modifier 52 or Modifier 53 may be added to CPT codes as appropriate and will be processed as noted below.

Modifier 52 - Reduced Services

CPT description: "Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service."

Modifier 52 is used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. This modifier is valid on CPT codes where the services described by the code are provided but are partially reduced and where Modifier 52 is permitted by CPT guidelines. It may not be used with most time-based codes. A 50% reduction in payment will be applied to all procedures reported with Modifier 52.

Do not report a surgery code with Modifier 52 if the procedure is cancelled or terminated before the patient is prepared for surgery and taken to the room where the procedure is to be performed. If documented, an Evaluation and Management (E&M) service may be reported if surgery is cancelled before the patient is prepared for surgery and taken to room where the procedure is to be performed.

Company will not pay separately for supplies that are rendered unusable due to reduced, cancelled, or discontinued services. Company will not pay for procedures that are terminated due to equipment failure.

Modifier 53 - Discontinued Procedure

CPT description: "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 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 individual for the discontinued procedure."

Modifier 53 may be added to the procedure code when a procedure is terminated after the induction of anesthesia (e.g. local, regional block(s), or general anesthesia), or after the procedure was started (incision made, intubation started, scope inserted). A 50% reduction in payment will be applied to all procedures reported with Modifier 53 unless there is a published RVU for that code with Modifier 53. In cases where there is a published RVU for the code with Modifier 53, the published RVU will be used for pricing.

This modifier is not used to report the elective cancellation of a procedure prior to administration of anesthesia or prior to start of the procedure. This modifier may not be used with E&M codes, laboratory codes, radiology codes, or time-based codes, including anesthesia codes.

Company will not pay separately for supplies that are rendered unusable due to reduced, cancelled, or discontinued services. Company will not pay for procedures that are terminated due to equipment failure.

REFERENCES

1. CMS/Medicare Rules and Regulations
2. Current Procedural Terminology (CPT)

POLICY REVISION HISTORY

Date	Revision Summary
3/2004	Original policy effective date.
1/2023	Annual review. Converted to new template 5/2023.
1/2024	Annual review. No changes to policy.
3/2024	Updated to clarify that "time-based codes" includes anesthesia. Modifier -53 is not allowed with time-based codes, including anesthesia codes.