

Coding Policy

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

CODING POLICY NUMBER: 57

Effective Date: 10/1/2026

Last Review Date: 9/2026

Next Annual Review: 2027

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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 |

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY STATEMENT

- I. Company recognizes Modifier 52 (*Reduced Services*) appended to a procedure code to indicate the scope of the service or procedure was partially reduced, procedure performed were significantly less than typically required or the procedure was eliminated at the physician’s discretion.

- II. Company recognizes Modifier 53 (*Discontinued Procedure*) appended to a professional service to indicate the procedure was either terminated or discontinued *after* induction of anesthesia or surgical preparation in the operative suite, due to circumstances beyond the control of the physician or circumstances that may affect the life of the patient.

PROCEDURE

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.

Medical records for the member must document why the procedure was discontinued and at what point in the surgery the procedure was discontinued.

Modifier 52 may not be reported with the following services

- An Evaluation and Management (E&M) service (except Preventive Medicine Services)
- A more descriptive procedure code that describes the lessor or reduced services
- Unlisted procedure codes
- Time-based codes, including anesthesia codes
- All-or-Nothing procedure codes
- Procedures cancelled or terminated before patient is prepared and taken to surgery room
 - If supported by documentation, 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.
- ASC or Outpatient facility services for which anesthesia is planned – see Coding Policy 39.0 (Modifiers -52, -73 and -74. Discontinued Services Outpatient/ASC Facility Charges).

Reimbursement for procedures appended with modifier 52 will be adjusted to reflect 50% of provider's applicable fee schedule allowed amount. 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).

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 may not be reported with the following services

- An Evaluation and Management (E&M) service
- Unlisted codes
- Time-based codes, including anesthesia codes
- Laboratory codes
- Radiology codes
- *Elective* cancellation of procedure *prior* to anesthesia induction/surgical preparation
- Laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure. The open procedure or more extensive procedure should be reported.
- ASC or Outpatient facility services – see Coding Policy 39.0 (Modifiers -52, -73 and -74. Discontinued Services Outpatient/ASC Facility Charges).

Reimbursement for procedures appended with modifier 53 will be adjusted to reflect 25% of the provider's applicable fee schedule allowed amount. Where there is a published RVU on the Medicare Physician Fee schedule (PFS) for the procedure code with modifier 53 appended, the published RVU will be used for pricing. 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.

CROSS REFERENCES

- Coding Policy 39.0 (Modifiers -52, -73 and -74. Discontinued Services Outpatient/ASC Facility Charges)

REFERENCES

1. Center for Medicare & Medicaid Services (cms.gov)
2. American Medical Association. 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.
1/2025	Annual review. No changes to policy.
9/2025	Annual Review date. Minor changes to formatting. Added Cross Reference section. Updated policy statement definition of modifiers 52 and 53. Changed reimbursement percentage for procedure codes appended with modifier 53 from 50% to 25% of fee schedule allowable amount. Clarified services that may not be reported with modifier 52 or modifier 53.
10/2026	Annual review. No changes to policy.