Discontinued Procedure Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

The term "Discontinued Procedure" designates a surgical or diagnostic procedure provided by a physician or other health care professional that was less than usually required for the procedure as defined in the Current Procedural Terminology (CPT®) book. Discontinued Procedures are reported by appending Modifier 53 (Discontinued Procedure). It is not appropriate to use Modifier 53 if a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.

Reimbursement Guidelines

Under certain circumstances such as a serious risk to the patient's well-being, 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 CPT coding guidelines, Modifier 53 should be used with surgical codes or medical diagnostic codes. Modifier 53 should not be used with:

- Evaluation and management (E/M) services

- Elective 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.

UnitedHealthcare's standard for reimbursement of Discontinued Procedures with Modifier 53 is 25% of the Allowable Amount for the primary unmodified procedure. Multiple procedure reductions will still apply.

For procedures that are partially reduced or eliminated at the physician's direction, see UnitedHealthcare's Reduced Services (Modifier 52) policy.

Definitions	
Allowable Amount	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
Discontinued Procedure; Modifier 53	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.

Resources
American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

History	
1/1/2024	Policy Version Change Logo Updated History Section: Entries prior to 1/1/2022 archived.
12/28/2008	Policy implemented by UnitedHealthcare Employer & Individual