DISCONTINUED PROCEDURE POLICY

Policy Number: ADMINISTRATIVE 206.12 T0 **Effective Date**: August 1, 2019

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Related Policy

- Refer to the Reimbursement Guidelines section of the policy

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

This reimbursement policy applies to services reported using the UB-04 claim form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500), or their electronic equivalents or their successor forms. This policy applies to all network and non-network providers, including hospitals, ambulatory surgical centers, 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.

OVERVIEW

The term "Discontinued Procedure" designates a surgical or diagnostic procedure provided by a physician, hospital, ambulatory surgical center 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, hospital, ambulatory surgical center 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.

Oxford'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 the *Reduced Services* policy (Modifier 52).

DEFINITIONS

Allowable Amount: The dollar amount eligible for reimbursement to the physician or health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of Allowable Amounts.

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.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Payment Policy Oversight Committee. [*2019R0110A*]

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.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
08/01/2019	• Routine review; no change to guidelines • Archived previous policy version ADMINISTRATIVE 206.11 T0