Payment Policy 60
Reduced Services and Discontinued Procedures, Professional and Facility

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Passport by Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document may supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a state, the federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Policy Overview

This payment policy is applicable to all healthcare services billed on UB04 forms (CMS 1450) and CMS 1500 forms. Our payment policy is developed by considering several factors such as coding methodology, industry-standard reimbursement criteria, regulatory mandates, benefits design, and other relevant considerations.

Modifier 52: Reduced Services

Per CPT coding guidelines: 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 signify the partial reduction or elimination of services such as radiology procedures and other procedures that do not require anesthesia. Modifier 52 should not be applied if a portion of the intended procedure was completed and there exists a corresponding code for that completed portion.

Modifier 52 should not be used to report the elective cancellation of a procedure prior to anesthesia induction, intravenous (IV) conscious sedation, or surgical preparation in the operating suite. Additionally, it is not appropriate to use modifier 52 with an evaluation and management (E/M) service.

Modifier 53: Discontinued Procedures

Per CPT coding guidelines: 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.

Modifier 53 is used to signify that a physician chose to terminate a surgical or diagnostic procedure due to extenuating circumstances that posed a risk to the patient's well-being. Modifier 53 should not be applied if a portion of the intended procedure was completed and there exists a corresponding code for that completed portion.

Modifier 53 should not be used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. Additionally, it is not applicable for facility billing and cannot be used in conjunction with an evaluation and management (E/M) service.

Modifier 73: Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Per CPT guidelines: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

Modifier 73 is exclusively utilized to signify discontinued procedures prior to the administration of anesthesia. It is not applicable in a professional setting.

Modifier 74: Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Per CPT guidelines: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

Modifier 74 is exclusively utilized to signify discontinued procedures after the administration of anesthesia. It is not applicable in a professional setting.

Reimbursement Guidelines

Reduced Services

- Modifier 52: The standard reimbursement rate for claims with modifier 52 is set at 100% of the contracted/negotiated rate for the procedure.

Discontinued Procedures

- Professional Claims: The standard reimbursement rate for claims with modifier 53 is set at 100% of the contracted/negotiated rate for the procedure.

- Facility Claims: If the procedure was discontinued before the administration of anesthesia, modifier 73 should be appended, and reimbursement will be at 50% of the contracted/negotiated rate for the procedure.

  If the procedure was discontinued after the administration of anesthesia, modifier 74 should be appended, and reimbursement will be at 100% of the contracted/negotiated rate for the procedure.

Audit and Recovery Process:

- **Review:** Claims will be meticulously examined against Passport by Molina Healthcare's standards.
- **Discrepancy Identification:** Any inconsistencies or errors identified will be documented.
- **Recovery:** Overpayments due to inaccuracies will be recovered either by offsetting from future payments or through direct refund requests.
- **Appeals:** Providers reserve the right to contest any claim adjustments or denials. Details of the appeal process will accompany the notification.

Policy Monitoring, Review, and Updates:

- The policy will undergo annual reviews or as required, ensuring its alignment with industry best practices, regulatory mandates, and Passport by Molina Healthcare's operational necessities. Any updates will be promptly communicated to providers.

Supplemental Information

Modifier Codes	
52	Reduced services
53	Discontinued procedure
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia
74	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Allowable Amount	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 the percentage of charge or discount contracts, the allowable amount is determined as the amount billed, less the discount.
Discontinued Procedure	Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. When necessary to indicate that a surgical or diagnostic procedure was started but discontinued a modifier is billed with the code. Physicians would append modifier 53 and facilities would append modifier 73 or 74.
Reduced Services	Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. The service provided would be billed with modifier 52 to signify that the service is reduced.

Documentation History

Type	Date	Action
Effective Date	09/01/2023	
Revised Date	07/03/2025	Modifier 52 and 53 reimbursement updated to 100%. Description of reduced and discontinued services added. Updated references.
Effective Date	01/17/2026	

References

1. **American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services**

2. **Centers for Medicare and Medicaid Services**
   - ***a.*** CMS Medicare Claims Processing Manual - Chapter 12
     Link: Medicare Claims Processing Manual
   - ***b.*** CMS Medicaid NCCI Coding Policy Manual
     Link: Medicaid NCCI Policy Manual | CMS
   - ***c.*** Healthcare Common Procedure Coding System, HCPCS (Healthcare Common Procedure Coding System) Release and Code Sets
     Link: Healthcare Common Procedure Coding System (HCPCS) | CMS

3. **Kentucky Medicaid**
   - ***a.*** Regulations
     Link: Title 907 • Kentucky Administrative Regulations • Legislative Research Commission
   - ***b.*** Provider Billing Manuals
     Link: KYHealth-Net
   - ***c.*** Fee Schedules
     Link: Fee Schedules - Cabinet for Health and Family Services (ky.gov)

This policy is designed to provide guidance and is not a guarantee of payment. Healthcare providers should make medical necessity determinations based on the individual clinical circumstances of each patient.