AmeriHealth Caritas Pennsylvania

Discontinued Procedures (Modifier 53, 73 and 74)

Reimbursement Policy ID: RPC.0019.05xx

Recent review date: 08/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes requirements for billing of discontinued procedures by providers contracted with the health plan. It also addresses billing for discontinued procedures (modifier 73 and 74) for ambulatory surgery centers (ASC's) and hospital outpatient procedures.

The health plan recognizes modifier 53 for discontinued procedures, consistent with Current Procedural Terminology (CPT) and American Medical Association (AMA) official guidance. Providers must submit clean claims using appropriate CPT/HCPCS codes and their modifiers, consistent with Pennsylvania Department of Human Services and other guidelines.

Exceptions

N/A

Reimbursement Guidelines

Providers
Consistent with Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) policy, modifier 53 should not be appended to multiple procedures, or to a procedure reported with multiple units, for the same date of service by the same provider. A physician or other qualified health care professional from the same group practice, with the same specialty and tax identification number (TIN), is considered the same provider.

When a procedure is completed after multiple attempts on the same date of service, only one instance of the procedure is reimbursable, and modifier 53 should not be appended.
When multiple procedures are planned for the same date of service:

- If any procedures are completed, only the completed procedures are reimbursable, and modifier 53 should not be appended.
- If no procedures are completed, only the first planned procedure is reimbursable as a discontinued procedure when reported with modifier 53.

Claims submitted with modifier 53 inappropriately appended will be denied.

Clinical documentation must identify the planned procedure, the reason the procedure was discontinued, and the portion or percentage of the procedure that was completed. Appropriate diagnosis coding may also support the reason the procedure was discontinued.

Facilities
Modifier 73 is used by outpatient hospitals and ambulatory surgery centers (ASCs) when a procedure is discontinued before anesthesia is administered due to extenuating circumstances. For example, a patient may be prepared for a hernia repair, but while awaiting anesthesia, the patient's blood pressure significantly increases and the procedure is canceled. The medical record must support the reason for discontinuation. Modifier 73 must be appended to the appropriate CPT code. Reimbursement to the facility will be 50 percent of the contracted reimbursement rate.

Modifier 74 is used when a procedure is discontinued after anesthesia has been administered due to extenuating circumstances. Examples may include a change in the patient's condition or an inability to complete the planned procedure because of anatomic anomalies. The medical record must support the reason for discontinuation. Modifier 74 must be appended to the appropriate CPT code and will be reimbursed at 100 percent of the contracted reimbursement rate.

Claims submitted with an inappropriately appended modifier will be denied.

Please refer to the CPT and HCPCS manuals for complete descriptions of procedures and modifiers, the ICD-10-CM manual for diagnosis coding guidelines and descriptions, and the Pennsylvania Department of Human Services for applicable fee schedules and billing guidelines.

Definitions

Modifier 53 - Discontinued Procedure
May be used only when a physician or other qualified health care professional elects to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well-being of the patient.

Modifier 73 –Discontinued Procedure, Hospital Outpatient and Ambulatory Surgery Center, Before Anesthesia
Modifier 73 is used when a procedure is discontinued due to extenuating circumstances that threaten the well-being of the patient before anesthesia is administered.

Modifier 74 - Discontinued Procedure, Hospital Outpatient and Ambulatory Surgery Center, After Anesthesia
Modifier 74 is used when a procedure is discontinued due to extenuating circumstances that threaten the well-being of the patient after administration of anesthesia.

Same Individual Physician or Other Qualified Health Care Professional
A physician or other health care professional from the same group practice with the exact same specialty and subspecialty reporting under the same Federal Tax Identification number (TIN).

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. The Centers for Medicare and Medicaid Services (CMS) National Correct Coding Policy (NCCI): https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci
V. The National Correct Coding Initiative (NCCI).
VI. Applicable health plans manual reference.
VII. Commonwealth of Pennsylvania Medicaid Program guidance.
VIII. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
08/2026	Reimbursement Policy Committee Approval
07/2026	Annual review • No major changes
04/2026	Reimbursement Policy Committee Approval
12/2025	Annual review • Addition of modifiers 73 and 74
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
10/2024	Annual review • Updated Definitions
04/2024	Revised preamble

10/2023	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by the health plan from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section
10/2023	Reimbursement Policy Committee Approval