Keystone First
VIP Choice.

Discontinued Procedures (Modifier 53, 73 and 74)

Reimbursement Policy ID: RPC.0019.PA01

Recent review date: 09/2026

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.

Exceptions

N/A

Reimbursement Guidelines

Providers
The health plan will deny claims where modifier 53 is reported for procedures that were discontinued in outpatient settings, before the induction of anesthesia, and/or electively. Claims for evaluation and management (E/M) services with modifier 53 appended will be denied. Claims for time-based procedures with modifier 53 appended will also be denied.

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 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 under the same specialty under and same tax identification number (TIN) is considered the same provider.

When a procedure was completed after multiple attempts on the same date of service, only one (1) instance of the procedure is reimbursable, without modifier 53.
When multiple procedures were planned for the same date of service:

- If any procedures were completed, only those procedures are reimbursable, without modifier 53.
- If no procedures were completed, only the first procedure is reimbursable as a discontinued procedure, with modifier 53.

Claims with modifier 53 inappropriately appended will be denied.

Facilities
Modifier 73 is used for billing procedures by outpatient hospitals and ASCs when a procedure is canceled before anesthesia is administered due to extenuating circumstances. For example, the patient has been prepped for a hernia repair. While waiting for the anesthesiologist, the patient's blood pressure spikes and the procedure is cancelled. Documentation in the medical record must reflect this information. Modifier 73 is appended to the appropriate CPT code. Reimbursement to the facility will be 50 percent of the contracted reimbursement rate.

Modifier 74 is used when the procedure was discontinued after the administration of anesthesia due to extenuating circumstances. For example, a change in the patient's condition or the surgeon is not able to complete the procedure due to anatomic anomalies preventing the planned procedure. Documentation in the medical record must reflect this information. Modifier 74 should be appended to the appropriate CPT code and will be reimbursed at 100% of contracted reimbursement rate.

Any claim with an inappropriately appended modifier will be denied.

Clinical documentation must state the plan for the procedure, the reason for which the procedure was discontinued, and the portion/percentage of the procedure that was completed. Appropriate diagnosis coding may also indicate the reason for which the procedure was discontinued.

Please refer to CPT/HCPS manuals for complete descriptions of procedures and modifiers, to the ICD-10-CM manual for guidelines and descriptions of diagnoses and other conditions.

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-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	Reimbursement Policy Committee Approval
08/2026	Annual review • Removed the next review date • Replaced the plan name with “the health plan”
03/2026	Reimbursement Policy Committee Approval
12/2025	Annual review • Addition of modifiers 73 and 74
04/2025	Revised preamble
12/2024	Reimbursement Policy Committee Approval
10/2024	Annual review • Updated definitions
04/2024	Revised preamble
12/2023	Reimbursement Policy Committee Approval