

Reimbursement Policy

Modifiers 52, 53, 73, and 74: Reduced and Discontinued Services

Policy Number: G-10033

Policy Section: Coding

Last Approval Date: 10/23/2025

Effective Date: 10/23/2025

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Policy

The health plan allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

If the reduced or discontinued procedure is performed with an assistant surgeon or in conjunction with multiple surgeries, assistant surgeons, and/or multiple procedure rules and fee reductions apply.

We reserve the right to perform post-payment review of claims submitted with modifiers 52, 53, 73, and 74.

Related Coding

- Modifier 52 - Reimbursement is reduced to 50% of the applicable fee schedule or contracted/negotiated rate. Do not report modifier 52 on time-based evaluation and management (E/M) and consultation codes.
- Modifier 53 - Professional reimbursement is reduced to 50% of the applicable fee schedule or contracted/negotiated rate. Modifier 53 is not applicable for facility billing and is not valid when billed on time-based E/M codes.
- Modifier 73 - Facility reimbursement is reduced to 50% of the applicable fee schedule or contracted/negotiated rate. Modifier 73 is not applicable for professional provider billing

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- Modifier 74 - Facility reimbursement is 100% of the applicable fee schedule or contracted/negotiated rate. Modifier 74 is not applicable for professional provider billing.

Definitions

- **Modifier 52: Reduced Services:** Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified healthcare 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. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
- **Modifier 53: Discontinued Procedure:** Under certain circumstances, the physician or other qualified healthcare 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. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use)
- **Modifier 73: Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia:** 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 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. For physician reporting of a discontinued procedure, see modifier 53.
- **Modifier 74: Discontinued Outpatient Hospital/Ambulatory Surgery Procedure After Administration of Anesthesia:** 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

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of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

- General Reimbursement Policy Definitions

Related Policies and Materials

- Modifier Usage
- Modifiers 50 and 51: Multiple and Bilateral Surgery
- Modifiers 80, 81, 82, and AS: Assistant at Surgery

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Code of Federal Regulations (CFR)
- Optum EncoderPro 2024
- State Medicaid

Policy History

- 10/23/2025 - Review approved and effective: no changes
- 12/14/2023 - Review approved and effective: updated policy title from Reimbursement for Reduced and Discontinued Services
- 11/18/2021 - Review approved and effective: updated policy template; moved definitions to Definitions section
- 07/01/2021 - Initial approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT[®]) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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