AmeriHealth Caritas Louisiana

Discontinued Procedures (Modifier 53)

Reimbursement Policy ID: RPC.0019.2100

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.

Exceptions

N/A

Reimbursement Guidelines

Providers
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 Louisiana Department of Health and other guidelines.

Consistent with CMS and the National Correct Coding Initiative (NCCI), 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.

Claims with modifier 53 inappropriately appended 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.
Any claim with an inappropriately appended modifier will be denied.

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, for Louisiana Department of Health and the Louisiana State 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.

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.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
IV. https://ldh.la.gov/assets/medicaid/MCPP/11.18.22/1/1497_LHCC_LA.PP.028_Modifier_to_Procedure_Code_Validation_8.22.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

10/2026	• 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
02/2026	Reimbursement Policy Committee Approval
12/2025	Annual review • No major changes
04/2025	Revised Preamble
07/2024	Reimbursement Policy Committee Approval
	Precedes Act 319