



PROVIDER REIMBURSEMENT GUIDANCE		
Reduced Services and Discontinued Procedure Payment Policy		
Original Date Approved	Effective Date	Revision Date
04/08/2022	7/1/2026	4/21/2026

Scope: Commonwealth Care Alliance (CCA) Product Lines

- Senior Care Options (FIDE-SNP)
- One Care (FIDE-SNP)

PAYMENT POLICY SUMMARY:

Based on American Medical Association (AMA) and Current Procedural Terminology (CPT) guidelines, CCA will reimburse services that are partially reduced or discontinued under specific circumstances.

In accordance with the AMA, certain circumstances require a service or procedure to be partially reduced or eliminated at the physician’s discretion. CCA will reimburse such circumstances as defined in the Current Procedural Terminology (CPT®) book. In this situation, the service or procedure provided can be reported by its usual procedure code the addition of Modifier 52 Reduced Services, which signifies the service was reduced and does not disturb the identification of the basic service.

Modifier 52 should be applied to services or procedures which represent diagnostic or surgical services that were reduced.

It is not appropriate to use Modifier 52 if a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.

CCA recognizes Modifier 53 when appended to a service to indicate that a surgical or diagnostic medical procedure was either terminated or was started after induction of anesthesia but discontinued due to extenuating circumstances beyond the control of the physician, the other qualified healthcare professional or the patient.

REIMBURSEMENT REQUIREMENTS:



Reduced Services CCA will reimburse services billed with a Modifier 52 at 50% of the contracted amount for the unmodified procedure.

- Modifier 52 should not be used to report the elective cancellation of a procedure before anesthesia induction, intravenous (IV) conscious sedation, and/or surgical preparation in the operating suite.
- Modifier 52 should not be used with an evaluation and management (E&M) service.
- Modifier 52 should only be reported with one procedure code.

Discounted Procedures

A discontinued procedure indicates a surgical or diagnostic procedure provided by a physician or other health care professional that was less than usually required for the procedure as defined in the Current Procedural Terminology (CPT®) book and are reported by appending Modifier 53.

- Modifier 53 indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. It is not appropriate to use Modifier 53 if a portion of the intended procedure was completed and a code exists which represents the completed portion of the intended procedure.
- The CCA standard for reimbursement of Modifier 53 is 50% of the contracted amount for the unmodified procedure.
- Modifier 53 is not applicable for facility billing and is not valid when billed with E&M or time-based codes.

- Modifier 73 Procedure discontinued prior to anesthesia administration.

Modifier 73 is used to report discontinued outpatient hospital or ambulatory surgery center (ASC) procedures that are stopped prior to anesthesia administration, which includes general, local, regional blocks, moderate sedation, or deep sedation. It applies only to surgical and certain diagnostic procedures—not radiology—and is reserved for extenuating circumstances where patient safety is at risk. The patient must be brought to the procedure room to use this modifier. Elective cancellations are not reported with Modifier 73. When possible, report a CPT code reflecting the extent of the procedure performed; if any planned procedures are completed, report those normally and omit codes for procedures not started. If none are completed, report the first planned procedure with Modifier 73.

- The CCA standard for reimbursement of Modifier 73 is 50% of the contracted amount for the unmodified procedure.

- Modifier 74 Procedure discontinued after anesthesia or procedure initiation.

Modifier 74 is used to report discontinued outpatient hospital or ambulatory surgery center (ASC) procedures that are stopped after anesthesia administration or once the procedure has begun (e.g., incision made, intubation started). It applies only to surgical and certain diagnostic procedures—not radiology—and is reserved for extenuating



circumstances threatening patient safety. The patient must be brought to the procedure room to report this modifier; elective cancellations are not reported with Modifier 74. When possible, report a CPT code reflecting the extent of the procedure performed; completed procedures are reported as usual, and procedures not started are not reported. If none of the planned procedures are completed, report the first planned procedure with Modifier 74.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to a refund of all payments related to non-compliance. CCA reserves the right to amend this payment policy at its discretion, to be binding on Provider. ICD, CPT/HCPCS codes are updated as applicable and such updates shall be deemed automatically incorporated into this Policy; providers must adhere to the most recent ICD, CPT/HCPCS coding guidelines, as applicable.

REFERENCES:

- American Medical Association (AMA) Current Procedural Terminology (CPT®)
 - cms.gov
 - CMS Medicare Claims Processing Manual - Chapter 04 - Part B Hospital (Including Inpatient Hospital Part B and OPSS): Section 20.6.4, 20.6.6
 - CMS Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Section 20.4.6, 30.1, 30.6.1, 40.2, 40.4A
 - CMS Medicare Claims Processing Manual - Chapter 13 - Radiology Services and Other Diagnostic Procedures: Section 80.1
 - CMS Medicare Claims Processing Manual - Chapter 23 - Fee Schedule Administration and Coding Requirements: Addendum • Commonwealth Care Alliance
- [0157-Discontinued Procedure Prior to the Administration of Anesthesia: Documentation Requirements | CMS](#)
- [42 CFR § 419.44 Payment reductions for procedures - Code of Federal Regulations](#)

POLICY TIMELINE DETAILS

1. Effective 08/01/2022
 2. Effective 7/1/2026
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