3/2 moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM049
Policy Title:	Modifiers 73 & 74 - Discontinued Procedures For Facilities		
Section:	Facility-Specific	Subsection:	Modifiers

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☐ All dates ☒ Specific date(s): July 1, 2018 & following ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☒ Date of processing (regardless of the date of service on the claim)
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	7/1/2018	Initially Published:	3/29/2018
Last Updated:	11/7/2022	Last Reviewed:	11/9/2022
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		11/9/2022	

Reimbursement Guidelines

A. General Policy Statement:

When planned procedures are discontinued in the ASC or outpatient hospital, the facility fee allowance may be reduced, depending upon when and why the procedure was discontinued.

Reimbursement depends upon these factors:

1. Whether the discontinuation of the procedure was for elective reasons, medical complications which threatened the patient safety and wellbeing, or other extenuating circumstances.
2. Whether anesthesia was or was not planned for the procedure.
3. Whether the patient had been taken to the procedure room.
4. Whether the planned anesthesia had been administered or not at the time the procedure was discontinued.

B. Correct Coding for Modifiers 73 & 74:

1. Modifiers 73 and/or 74 Modifier 53 are considered valid on a maximum of one procedure code per date of service.
    a. It is never appropriate to report more than one procedure code with modifier 73/74.

b. When none of the planned procedures is completed, then the first planned procedure is reported with modifier 73/74. The other planned procedure(s) are not reported.
    i. Modifier 50 and modifier 73/74 may not be reported together on the same procedure code.
    ii. When a bilateral procedure is planned and discontinued before either side is completed, only a unilateral procedure code may be reported with modifier 73/74.
c. If one or more of the procedures planned is completed, the completed procedures are reported as usual. The other procedure(s) that are discontinued or not completed are not reported and are not eligible for separate reimbursement.

2. Modifiers 73 and/or 74 are not appropriate to append to add-on codes. Use with the primary/parent procedure code only.

3. By definition, modifiers 73 and 74 are only to be reported on outpatient hospital claims and ambulatory surgery center (ASC) claims. Modifiers 73 and 74 may not be reported by physicians on surgeon or assistant surgeon claims.

C. Determining factors and requirements.

1. Anesthesia.
   For purposes of billing for services furnished in the hospital outpatient department or ASC, anesthesia is defined to include:
   a. Local block(s).
   b. Regional block(s).
   c. Moderate sedation/analgesia ("conscious sedation").
   d. Deep sedation/analgesia.
   e. General anesthesia.

2. Reasons for cancelation.
   a. Elective cancelation.
      i. The elective cancellation of a procedure should not be reported.
      ii. Procedures cancelled for elective reasons are not eligible to be reported or reimbursed. Elective reasons include (but are not limited to):
         1) Patient didn't show for the procedure.
         2) Patient is noncompliant.
         3) Patient changed their mind about having the procedure or having it today.
         4) Facility needed to reschedule due to various reasons (e.g., space availability, staffing concerns, supply issues, physician's schedule changed, etc.).
   b. Cancellation due to medical complications.
      i. Cancellation because the patient's medical condition suddenly and unexpectedly changed with a risk to the patient's wellbeing are eligible to be reported with modifier 73 or 74.
      ii. Examples include (but are not limited to):
         1) The patient develops an allergic reaction to a drug administered at the facility.
         2) Upon injection of a retrobulbar block, the patient experiences a retrobulbar hemorrhage which prevents beginning the procedure.

3) After anesthesia has been accomplished and the surgeon has made a preliminary incision, the patient's blood pressure suddenly increases and the surgery is terminated to avoid increasing surgical risk to the patient.

c. Other extenuating circumstances.
   i. Cancellation for other extenuating circumstances not related to complications are also eligible to be reported with modifier 73.
   ii. The "extenuating circumstances" should be unanticipated, not avoidable, and occurring after the patient is prepared and taken to the procedure room.

3. Documentation for discontinued or terminated procedures.
   a. In all cases when facilities report discontinued or terminated procedures with a modifier 73, 74, or 52 for reimbursement, the facility needs to keep a copy of the procedure documentation on file and available to submit for claim review upon request.

   b. The facility is responsible to coordinate with the surgeon or physician to ensure the documentation includes the following information:
      i. Reason for termination of surgery;
      ii. Services actually performed;
      iii. Supplies actually provided;
      iv. Services not performed that would have been performed if surgery had not been terminated;
      v. Supplies not provided that would have been provided if the surgery had not been terminated;
      vi. Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
      vii. Time that would have been spent in each of these stages if the surgery had not been terminated;
      viii. CPT or HCPCS code for procedure had the surgery been performed.

D. Procedure terminated/discontinued before anesthesia is provided.

1. Procedures which are discontinued or terminated before planned anesthesia has been provided should be reported with modifier 73.
   a. The patient must be prepared for the procedure and taken to the room where the procedure is to be performed to report modifier 73.
   b. Modifier 73 may not be used if anesthesia was not planned for the procedure.

2. Procedures reported with modifier 73 appended will be reimbursed at 50% of the applicable fee schedule rate for the facility.
   a. For device-intensive procedures reported by outpatient hospitals with modifier 73 appended, the allowable amount for the discontinued device-intensive procedure will be reduced by 100 percent of the device offset amount prior to applying the modifier 73 reduction.
   b. Modifier 73 provides a way for hospitals and ASCs to report and be paid for expenses incurred. Some supplies and resources are expended, but they are not consumed to the same extent had anesthesia been fully induced and the surgery completed. (CMS[2])
   c. The reimbursement for modifier 73 includes:
      i. Preparing a patient for a procedure with anesthesia.
      i. Procedural pre-medication when provided.
      ii. Scheduling a room for performing the procedure.
      iii. Resources expended in the procedure room.
      iv. Resources expended in the recovery room (if needed). (CMS[1])

d. The member's usual copayment, coinsurance, and deductible provisions apply.

3. Multiple procedures.
   a. Modifier 73 is considered valid on a maximum of one procedure code for the patient encounter.
   b. When one or more of the planned procedures is completed, report the completed procedure as usual. Any others that were planned and not started are not reported.
   c. When more than one procedure is planned and none of the planned procedures are completed, the first procedure that was planned to be done is reported modifier 73. Any others that were planned and not started are not reported.
   d. When a bilateral procedure is planned and is discontinued/terminated, only a unilateral procedure (the first side) may be reported with modifier 73. The second side is not reported. Do not report modifier 50 in combination with modifier 73 on the same procedure code.
   e. Multiple procedure price reduction rules do not apply, since only one procedure code will be reported.

E. Procedure terminated/discontinued after anesthesia is induced or the procedure is initiated.

1. Procedures which are discontinued or terminated after anesthesia is induced or the procedure is initiated should be reported with modifier 74.
   a. The patient must be prepared for the procedure and taken to the room where the procedure is to be performed to report modifier 74.
   b. Modifier 74 may not be used if anesthesia was not planned for the procedure.
2. Procedures reported with modifier 74 appended will be reimbursed at the usual applicable fee schedule rate for the facility.
   a. The resource requirements for procedures discontinued or terminated after anesthesia is induced or the procedure is initiated are somewhat less, but similar to, the resources expended if the planned procedures had been completed.
   b. The reimbursement for modifier 74 includes:
      i. Preparing a patient for a procedure with anesthesia.
      ii. Procedural pre-medication when provided.
      iii. Scheduling a room for performing the procedure.
      iv. Resources expended in the procedure room.
      v. Resources expended in the recovery room (if needed). (CMS[1])
   c. The member's usual copayment, coinsurance, and deductible provisions apply.

F. Procedures for which anesthesia is not planned that are terminated, discontinued, or reduced.

1. Procedures may be performed in the ASC or outpatient hospital department for which anesthesia is not planned (e.g., discontinued radiology procedures and other procedures that do not require anesthesia).
2. When these procedures are terminated, discontinued, or otherwise reduced after the patient is prepared and taken to the room where the procedure is to be performed, report with modifier 52.
   a. Note: Modifiers 73 and 74 are not appropriate, because no anesthesia is planned.
   b. Please reference "Modifier 52 – Reduced Services." Moda Health Reimbursement Policy Manual, RPM003 (Moda[A]) for the guidelines which apply.

G. Use of modifier 53.

1. Modifier 53 is used to indicate discontinuation of physician & professional services only and is not approved for use by outpatient hospital services or ASCs. (CMS[1])
2. Procedures reported by ASCs or outpatient hospitals with modifier 53 appended will be denied. This is an invalid use of modifier 53. (CMS[1])

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
ASO	=	Administrative Services Only
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit(s)
UB	=	Uniform Bill

Modifier Definitions:

Modifier	Modifier Description & Definition
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 for 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 Center (ASC) 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 of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.
Modifier 52	**Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. 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 -52 identifies that the service or procedure has been partially reduced or eliminated at the physician's discretion. The basic service described by the procedure code has been performed, but not all aspects of the service have been performed.

Modifier	Modifier Description & Definition
Modifier 53	**Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care 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.)

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for a procedure and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers.

Modifier -73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, or general anesthesia. This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued." (CMS[1])

"Coinciding with the addition of the modifiers -73 and -74, modifiers -52 and -53 were revised. Modifier -52 is used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier -53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.**"** (CMS[1])

"An ASC claim for payment for terminated surgery must include an operative report kept on file by the ASC, and made available, if requested by the contractor. The operative report should specify the following:

- Reason for termination of surgery;
- Services actually performed;
- Supplies actually provided;
- Services not performed that would have been performed if surgery had not been terminated;
- Supplies not provided that would have been provided if the surgery had not been terminated;
- Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
- Time that would have been spent in each of these stages if the surgery had not been terminated; and
- HCPCS code for procedure had the surgery been performed." (CMS[2])

Cross References

A. "Modifier 52 – Reduced Services." Moda Health Reimbursement Policy Manual, RPM003.

B. "Modifier 53 – Discontinued Procedure." Moda Health Reimbursement Policy Manual, RPM018.

C. "Modifier 50 – Bilateral Procedure." Moda Health Reimbursement Policy Manual, RPM057.

References & Resources

1. CMS. Medicare Claims Processing Manual (Pub. 100-4). Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS, § 20.6.4.

2. CMS. Medicare Claims Processing Manual (Pub. 100-4). Chapter 14 – Ambulatory Surgical Centers, §40.4.

3. American Medical Association. "Coding Consultation - Female Genital System, 58300, 58301 (Q&A)." CPT Assistant. Chicago: AMA Press, April 1998, p. 14.

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider

- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
11/9/2022	Formatting & clarification/Update: Change to new header; includes Idaho. Changed Section from Modifiers to Facility-Specific & added Subsection of Modifiers. Section A: General Policy Statement minor rephrasing. Section B: Items moved out of General Policy Statement into a separate section to simplify Section A. B.3 added. Modifier Table: Modifier 53 added, since it is mentioned in Section G. Cross References: Hyperlinks added. Policy History: Corrected Original Effective Date. (11/16/2017 was previously listed, but this was origin of work on policy rather than when it became effective.)
3/29/2018	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
7/1/2018	Original Effective Date (with or without formal documentation). Policy based on CMS policy, Pub. 100-04, ch. 4, § 20.6.4 & ch. 14 §40.4. (CMS[1, 2])