Modifiers 73 & 74 - Discontinued Procedures For Facilities

Last Updated: 5/14/2025 **Last Reviewed: 5/14/2025** **Originally Effective: 7/1/2018**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM049**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

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 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. [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).[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).[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[B] 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.[1]
2. Procedures reported by ASCs or outpatient hospitals with modifier 53 appended will be denied. This is an invalid use of modifier 53.[1]

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
ASC	Ambulatory Surgery Center
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)

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	Modifier Description & Definition
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 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.)

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Modifier 52 – Reduced Services." Moda Health Reimbursement Policy Manual, RPM003.
C. "Modifier 53 – Discontinued Procedure." Moda Health Reimbursement Policy Manual, RPM018.
D. "Modifier 50 – Bilateral Procedure." Moda Health Reimbursement Policy Manual, RPM057.

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.

Policy History

Reminder: 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 current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
5/14/2025	Acronyms & Related Policies updated. Formatting updates. No policy changes.
5/8/2024	Formatting updates. No policy changes.
4/12/2023	Clarification-fixed typo: Removed "Modifier 53" from section B.1.
11/9/2022	Idaho added to Scope. Corrected Original Effective Date. Changed to Facility-Specific Section. General Policy Statement added. Clarified which provider types may bill modifiers 73 & 74. Modifier Table updated. Policy History section added; entries prior to 2022 omitted (in archive storage). Minor rephrasing. Formatting updates. No policy changes.
3/29/2018	Policy document 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. [1, 2]