EmblemHealth

Payment Policy:
Discontinued Procedures/Reduced Services – Modifiers 52, 53, 73 & 74 (Commercial)

Effective Date: 1/01/2021 | **Number: RP20210006**

Reimbursement Guideline

Disclaimer: EmblemHealth has policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. EmblemHealth will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in EmblemHealth's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by EmblemHealth due to programming or other constraints; however, EmblemHealth strives to minimize these variations.

EmblemHealth follows coding edits that are based on industry sources, including, but not limited to; CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. EmblemHealth uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how EmblemHealth handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, EmblemHealth may deny the claim and/or recoup claim payment.

Overview

The term "Discontinued Procedure" designates 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.
This policy describes the billing instructions and guidelines when billing for a discontinued procedure using modifiers 53, 73 or 74.

Discontinued Procedure -*Modifiers 73 & 74:

**Ambulatory Surgery Centers (ASCs) and Outpatient Hospital facilities*

Modifier	Description
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.*

EmblemHealth

Payment Policy:
Discontinued Procedures/Reduced Services – Modifiers 52, 53, 73 & 74 (Commercial)

Modifier	Description
74	***Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure <u>After</u> 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 <u>after</u> 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.* *<u>For physician reporting of a discontinued procedure, see modifier 53.</u>*

Coding Guidelines:

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. The following is applicable to <u>both outpatient hospital departments and to ambulatory surgical centers (ASC)</u>.

Claims submitted for payment for terminated surgery <u>must</u> include an operative report kept on file by the ASC, and made available, if requested. 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

Reimbursement Guidelines (Modifiers 73/74):

When planned procedures are discontinued in the ASC or outpatient hospital, the facility fee allowance will be reduced, depending upon:

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

EmblemHealth

Payment Policy:
Discontinued Procedures/Reduced Services – Modifiers 52, 53, 73 & 74 (Commercial)

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. Reason(s) for cancellation
   a. Elective cancellation:
      1) Patient did not show for the procedure
      2) Patient is non-compliant
      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:
      1) Cancellation because the patient's medical condition suddenly and unexpectedly changed with a risk to the patient's well-being. Examples include (but are not limited to):
         - The patient develops an allergic reaction to a drug administered at the facility.
         - Upon injection of a retrobulbar block, the patient experiences a retrobulbar hemorrhage which prevents beginning the procedure.
         - After anesthesia has been accomplished and the surgeon has made a preliminary incision, the patient's blood pressure increases suddenly and the surgery is terminated to avoid increasing surgical risk to the patient.
   c. Other extenuating circumstances:
      1) Cancellation for other extenuating circumstances not related to complications
      2) 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:
      1) Reason for termination of surgery;
      2) Services actually performed;
      3) Supplies actually provided;
      4) Services not performed that would have been performed if surgery had not been terminated;
      5) Supplies not provided that would have been provided if the surgery had not been terminated;

6) Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
7) Time that would have been spent in each of these stages if the surgery had not been terminated;
8) CPT or HCPCS code for procedure had the surgery been performed.

Procedure terminated/discontinued before anesthesia is provided.

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

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.

The reimbursement for modifier 73 includes:

- Preparing a patient for a procedure with anesthesia.
- Procedural pre-medication when provided.
- Scheduling a room for performing the procedure.
- Resources expended in the procedure room.
- Resources expended in the recovery room (if needed).
- The member's usual copayment, coinsurance, and deductible provisions apply.

Multiple Procedures and Modifier 73:

- Modifier 73 is considered valid on a maximum of one procedure code for the patient encounter.
- 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*.
- 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.*
- 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.*
- Multiple procedure price reduction rules do not apply, since only one procedure code will be reported.

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

a. Procedures which are discontinued or terminated after anesthesia is induced or the procedure is initiated should be reported with modifier 74.
    1) The patient must be prepared for the procedure and taken to the room where the procedure is to be performed to report modifier 74.
    2) Modifier 74 may not be used if anesthesia was not planned for the procedure.

EmblemHealth

Payment Policy:
Discontinued Procedures/Reduced Services – Modifiers 52, 53, 73 & 74 (Commercial)

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, therefore procedures reported with modifier 74 appended will be reimbursed at the usual applicable fee schedule rate for the facility

The reimbursement for modifier 74 includes:

- Preparing a patient for a procedure with anesthesia.
- Procedural pre-medication when provided.
- Scheduling a room for performing the procedure.
- Resources expended in the procedure room.
- Resources expended in the recovery room (if needed).
- The member's usual copayment, coinsurance, and deductible provisions apply.

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

- 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).
- 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.

Note: Modifiers 73 and 74 are not appropriate, because no anesthesia is planned

Reduced Services (Modifier 52):

Modifier	Description
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.*

1. A maximum of one terminated or discontinued procedure may be reported with modifier 52
   a. Do not submit CPT modifier 52 to report an elective cancellation of a procedure before anesthesia induction and/or surgical preparation in the operating suite. You may not submit CPT modifier 52 if the procedure is discontinued after administration of anesthesia.

b. When multiple procedures are planned, and 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 multiple procedures are planned, and none of the planned procedures are completed, report the first planned and discontinued procedure with modifier 52 appended. *The remaining procedures which were planned and not started are not reported.*
d. When a bilateral procedure without anesthesia is planned and discontinued after the patient arrives in the procedure room, only a unilateral procedure (the first side) may be reported as discontinued with modifier 52 appended. The second side is not reported. *Do not report modifier 50 in combination with modifier 52 on the same procedure code.*
e. When multiple procedures are planned, one or more of the planned procedures is completed, and another planned procedure is performed but reduced at the discretion of the physician*:*
    1) The completed procedures are reported as usual
    2) The performed but reduced procedure is reported with modifier 52 appended
    3) Any other planned procedures not performed or started are not reported

Procedures reported by ASCs or outpatient hospitals with modifier 52 appended will be reimbursed at 50% of the usual applicable fee schedule rate for the facility fee. The member's usual copayment, coinsurance, and deductible provisions apply.

Discontinued Procedure (*Modifier 53)

** Physician & professional services only and is not approved for use by outpatient hospital services or ASCs. Procedures reported by ASCs or outpatient hospitals with modifier 53 appended will be denied.*

Modifier	Description
53	**Discontinued Procedure (physician & professional services *only*):** 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*

Reimbursement Guidelines:

1. Modifier 53 is considered valid on a maximum of one procedure code per date of service.
    a. Do not submit CPT modifier 53 to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

b. Do not submit CPT modifier 53 when a laparoscopic or endoscopic procedure is converted to an open procedure
c. When multiple procedures were planned:
    1) It is never appropriate to report more than one procedure code with modifier 53.
    2) When none of the planned procedures is completed, then the first planned procedure is reported with modifier 53. *The other planned procedure(s) are not reported*.
d. Modifier 50 and modifier 53 may not be reported together on the same procedure code.
    1) When a bilateral procedure is planned and discontinued before either side is completed, only a unilateral procedure code may be reported with modifier 53.
e. 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.

Exceptions:

- Upper GI and Lower GI procedures, same day:
    - The only time it is appropriate to report a discontinued procedure with modifier 53 in combination with completed procedure codes is when the completed procedures are upper GI endoscopy procedures and the single, discontinued procedure is a lower GI endoscopy, or vice versa.
    - However, it is still not appropriate to report a completed lower GI procedure code in combination with a discontinued lower GI procedure code. In that case, only the completed lower GI code may be reported.

Providers will be reimbursed for one discontinued procedure with modifier 53. Additional discontinued procedures for the same date of service are not eligible for reimbursement.

Note: If surgery is cancelled after the Anesthesia Professional has prepared the patient for induction, report the most applicable anesthesia code with full base and time. The Anesthesia Professional is not required to report the procedure as a discontinued service using modifier 53.

Documentation Requirements:

The medical record must include documentation that the procedure was started, why the procedure was discontinued, and the percentage of the procedure that was performed. This supporting documentation must be available for review upon request.

References

1. American Medical Association, *Coding with Modifiers*
2. American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
3. CMS. Medicare Claims Processing Manual (Pub. 100-4). Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS, § 20.6.4.
4. CMS. Medicare Claims Processing Manual (Pub. 100-4). Chapter 14 – Ambulatory Surgical Centers, §40.4.

EmblemHealth

Payment Policy:
Discontinued Procedures/Reduced Services – Modifiers 52, 53, 73 & 74 (Commercial)

Revision history

DATE	REVISION
2/2021	• New Policy
3/2021	• Added additional clarification regarding appropriate use of modifiers 52 & 53 • Policy title updated to include “Reduced Services – Modifier 52”