LifeWise Assurance Company

Payment Policy

cmi_051725

Title	**Modifier 73-Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia**		
Number	**CP.PP.245.v2.9**		
Last Approval Date	11/12/24	**Original Effective Date**	01/01/05
Cross Reference	• *Modifier 53 – Discontinued Procedure* • *Modifier 74 – Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia*		
Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.			
Purpose	To define when the Plan recognizes services appended with Modifier 73 that are submitted on a CMS 1450 paper claim or 837I electronic claim form.		
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.		

Policy	The Plan recognizes Modifier 73- *Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia* appended to a service to indicate that due to extenuating circumstances or those that threaten the wellbeing of the patient, a surgical or diagnostic procedure that requires anesthesia at an outpatient hospital or ambulatory surgical center (ASC) was discontinued **prior to** the administration of anesthesia, and before the surgical procedure was started. The patient must have already been wheeled into the surgical suite. Anesthesia includes local blocks, regional blocks, moderate sedation, deep sedation, or general anesthesia. Append modifier 73 to the intended surgical procedure code which represents the discontinued **ASC or outpatient facility service**. Documentation in the medical records must list why and when the physician decided to cancel the procedure, services and supplies that were/were not rendered, and the time spent preoperatively. Modifier 73 is only appended to a discontinued **ASC or outpatient facility service prior to** the administration of anesthesia and **before** the surgical procedure started when billed on a facility claim. Modifier 73 must not be appended in conjunction with the following: • **any** ASC or outpatient facility procedure that was electively discontinued by the patient or physician. • unlisted procedure codes • add-on procedure codes • professional services, or • after the administration of anesthesia Modifier 53-*Discontinued Procedure* should not be appended for any discontinued ASC or outpatient facility service since modifier 53 is appended to professional services only. Modifier 74- *Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia* is only appended to a discontinued ASC or outpatient facility service **after** the administration of anesthesia or after the procedure was started (incision made, intubation started, etc.) billed on a facility claim. Reimbursement for services appended with Modifier 73 will be adjusted to 50% of the applicable Fee Schedule allowed amount.

Violations of Policy	Violations of this policy by any party that enters a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None

References	• American Medical Association's Current Procedural Terminology (AMA/CPT) codebook
	• Centers for Medicare and Medicaid Services (CMS), Publication 100-04,
	  o Chapter 4-Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 20.6.4
	  o Chapter 14-Ambulatory Surgical Centers, Section 40.4

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	11/12/24; 02/05/24; 03/13/23; 04/08/22; 08/02/21; 08/17/20; 10/11/19; 10/18/18; 12/04/17; 08/11/17; 09/14/16; 01/08/16; 01/11/15; 01/12/14; 01/13/13/13/13; 01/26/12; 01/27/11; 02/12/10; 03/24/09; 06/16/08; 05/13/07; 04/11/06; 08/29/05; 07/30/04	
Version History	10/18/18	Annual Review; no changes
	10/11/19	• Clarified the kinds of applicable anesthesia in the first paragraph. • In the second paragraph, indicated that rationale for the discontinuation must be present in the medical records. • Added statement that the modifier cannot be used if the patient elects to discontinue procedure.
	08/17/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms
	08/02/21	• Clarified in the first paragraph that modifier 73 is applicable to surgical procedures that require anesthesia. • Identified the different kinds of anesthesia that could be performed. • Added additional information on documentation in the patient's medical record needed to support the use of modifier 73.
	04/08/22	• Added further clarification on the correct/incorrect use of Modifier 73. • Added new paragraph on the correct use of Modifier 74.
	03/13/23	Annual review; no changes
	02/05/24	In the Policy section, expanded the fifth paragraph with bulleted examples of when appending modifier 73 to a service is not appropriate.
	11/12/24	Annual Review; no changes

This policy was published on November 15, 2024