



Related MLN Matters Article #: MM3507

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Hospital Outpatient Prospective Payment System (OPPS): Use of Modifiers -52, -73 and -74 for Reduced or Discontinued Services

Key Words

CR3507, MM3507, R442CP, Modifiers, Anesthesia, Surgical, Diagnostic, OPPS

Provider Types Affected

Providers and hospitals paid under the OPPS by Medicare Fiscal Intermediaries (FIs)

Key Points

- The effective date of the instruction is February 22, 2005.
- The implementation date is February 22, 2005.
- Change Request (CR) 3507 was issued to clarify:
 - The definition of anesthesia for purposes of billing for services furnished in the hospital outpatient department and
 - The Centers for Medicare & Medicaid Services' (CMS) policy regarding the use of modifiers -52, -73, and -74 reported under OPPS.

Definition of Anesthesia

- For billing purposes 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; and
 - General anesthesia.

Use of Modifiers -52, -73, and -74

- The OPPS modifiers -52, -73 and -74 are used to report surgeries and certain diagnostic procedures requiring anesthesia and for procedures that are discontinued by a physician due to unforeseen circumstances.

- To provide additional clarity:
 - Modifier -73 is used by the facility to indicate a surgical or diagnostic procedure requiring anesthesia was terminated due to extenuating circumstances that threatened the well being of the patient after the patient had been prepared for the procedure and been taken to procedure room.
 - Modifier -74 is used by the facility to indicate that a surgical or diagnostic procedure requiring anesthesia was terminated after induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, or scope inserted).
 - Modifier -52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia.

Note: Discontinued radiology procedures that do not require anesthesia may not be reported using modifiers -73 and -74.

Effect on Payment

- The hospital may receive the full OPPS payment amount for the discontinued procedure if the procedure is discontinued after the beneficiary has received anesthesia, or the procedure was started (e.g., scope inserted, intubation started, incision made).
- The hospital may receive 50 percent of the OPPS payment amount for the discontinued procedure if the procedure is discontinued after the beneficiary was prepared for the procedure, **and** the beneficiary was taken to the room where the procedure was to be performed.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3507.pdf> on the CMS website.

The official instruction (CR3507) regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R442CP.pdf> on the CMS website.

If providers have any questions, they may contact their FI at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.