



Related Change Request (CR) #:3507

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

Note: This article was updated on February 16, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers and hospitals paid under the OPPS by Medicare fiscal intermediaries (FIs)

Provider Action Needed

This article and related CR 3507 clarifies 1) the definition of anesthesia for purposes of billing for services furnished in the hospital outpatient department and 2) the use of modifiers -52, -73 and -74 that are reported under OPPS for reduced or discontinued services.

Background

Because of recent questions received by the Centers for Medicare & Medicaid Services (CMS), CR 3507 was issued to clarify:

- The definition of anesthesia for purposes of billing for services furnished in the hospital outpatient department, and
- The CMS policy regarding the use of modifiers -52, -73, -74 reported under OPPS.

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, and

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- General anesthesia.

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

- The hospital **may receive 50 percent of the OPPS payment amount** for the discontinued procedure if:
 - The procedure is discontinued after 1) the beneficiary was prepared for the procedure **and** 2) the beneficiary was taken to the room where the procedure was to be performed.
- The hospital **may receive the full OPPS payment amount** for the discontinued procedure if:
 - The procedure is discontinued after 1) the beneficiary has received anesthesia **or** 2) the procedure was started (e.g., scope inserted, intubation started, incision made).

To provide additional clarity:

- Modifier –73 is used by the facility to indicate that 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 the procedure room.
- Modifier –74 is used by the facility to indicate that a surgical or diagnostic procedure **requiring anesthesia** was terminated after the induction of anesthesia or after the procedure was started, e.g., the 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 that discontinued radiology procedures that do not require anesthesia may not be reported using modifiers –73 and –74.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 4, has been revised to reflect these clarifications. The updated manual instructions are attached to the official instruction released to your intermediary. You may view that instruction at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R442CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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