Coding Policy

Modifiers -52, -73 and -74: Discontinued Procedures (Outpatient/ASC Facility Charges)

CODING POLICY NUMBER: 39

Effective Date: 1/1/2024
Last Review Date: 1/2024
Next Annual Review: 2025

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies"). **The full Company portfolio of current coding policies is available online and can be accessed here.**

POLICY APPLICATION

☒ Providence Health Plan Participating Providers ☒ Non-Participating Practitioners

☒ Commercial ☒ Medicaid/Oregon Health Plan ☒ Medicare

POLICY STATEMENT

I. Modifier 73 and modifier 74 are for facility use only and are used to report discontinued outpatient hospital/ASC procedures. Modifier 52 is used to indicate partial reduction, cancellation, or discontinuation of services and may be used for facility charges when anesthesia is not planned. Modifier 53 may be used only for professional charges. (See also Coding Policy 57.0.)

A. Modifier 73: "Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia"
B. Modifier 74: "Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia"

C. Modifier 52: "Reduced Services" May be used by facilities to report partial reduction, cancellation, or discontinuation of services when anesthesia is not planned. This modifier may be used for cancelled procedures only if the procedure is cancelled after the patient is prepared for surgery and has been taken to the room where the procedure is to be performed.

PROCEDURE

GENERAL

Modifier 52, 73 or 74 is appended to the CPT code for the surgical procedure with the following effect on payment:

- Modifier 73: Procedures discontinued prior to administration of anesthesia are paid at 50% of the facility ASC or outpatient rate.
- Modifier 74: There is no reduction in payment for procedures discontinued after administration of anesthesia. Modifier -74 is reported only if the procedure is terminated after administration of anesthesia. Due to extenuating circumstances or those that threaten the wellbeing 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.).
- Modifier 52: Procedures for which anesthesia is not planned that are discontinued, partially reduced, or cancelled after the patient is prepared and taken to the room where the procedure is to be performed are paid at 50% of the facility ASC or outpatient rate.
- Company will not pay separately for procedures that are terminated due to equipment failure.

REFERENCES

1. CMS/Medicare Rules and Regulations
2. Current Procedural Terminology (CPT)

POLICY REVISION HISTORY

Date	Revision Summary
7/2001	Original policy effective date.
1/2023	Annual review. Converted to new template 5/2023.
1/2024	Annual review. No changes to policy.