Outpatient Facility Coding Alert

Modifier Focus: Watch the Clock to Know Whether Modifier -73 or -74 Applies

Plus: Here's what your bottom-line difference will be.

Most procedures in your facility might go as planned, but sometimes circumstances lead to a procedure being discontinued. That's when modifiers 73 and 74 come into use, so follow the advice below so you'll know what they represent and when to report each one.

Context: Use modifiers -73 and -74 to report discontinued Outpatient/Hospital Ambulatory Surgery Center (ASC) procedures. These modifiers indicate a procedure that was cancelled after the patient's surgical preparation in an outpatient hospital/ambulatory surgery center (ASC) setting.

Early Cancellation Could Mean -73

Modifiers -73 and -74 both apply to discontinued procedures, but timing dictates which one is correct for the situation.

The basics: Modifier -73 indicates procedures discontinued prior to anesthesia administration. The descriptor (Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia) doesn't have many details, but Appendix A of CPT® gives a better picture of when it applies.

Here is what CPT® specifies, "Due to extenuating circumstances or those threatening the wellbeing of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including being taken to the room where the procedure is planned to be performed and sedation when appropriate)."

If this happens prior to the administration of anesthesia (local, regional block[s] or general), you should consider appending modifier -73. Since modifier -73 only applies in the facility setting, the physician would report his or her work using modifier 53 (Discontinued Procedure).

Example: A 65-year-old man was brought to the operating room for repair of a recurrent inguinal hernia. The patient was prepped and positioned. Before the administration of anesthesia, the patient complained of chest pain, with cardiac monitoring revealing ST segment changes. The procedure was cancelled. You need to report with CPT® code 49520-73 (Repair recurrent inguinal hernia, any age, reducible).

Important note: Remember, when there is an elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient in the operating suite, the procedure should not be reported.

Anesthesia Administration Drives Modifier -74 Usage

Modifier -74 (Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia), by contrast, is appropriate for surgical or diagnostic procedures discontinued after anesthesia administration or after the procedure has begun (incision made, intubation started, scope inserted).

Steer clear: There are certain times you cannot report modifier -74, even if the cancellation takes place after anesthesia administration. These situations include:

- When there is elective cancellation or postponement of a procedure based on the physician or patient's choice
- When the patient has not been wheeled into the OR suite
- For the reporting of professional fee services.

Example: A 65-year-old man was taken to the operating room for a laparoscopic cholecystectomy and anesthetized. After making the portal entry incision, the anaesthesiologist noticed the patient having ventricular fibrillation on the cardiac monitor. Defibrillation effort was tried two times, finally the arrhythmia abated. The procedure was cancelled pending further cardiac consultation. You need to bill the procedure as 47562-74 (Laparoscopy, surgical; cholecystectomy).

Know the Payment Implications

Effective 04/01/2013, reimbursement for modifier -73 for all procedures is 50 percent of the base APC fee schedule, according to Medicare guidelines. There is no reduction to reimbursement for Modifier -74. This is because the resources of the facility are used in the same manner and extent as they would have been had the complete procedure been done.

Caution: If these modifiers are not used and the patient has to come back for the same procedure, then reimbursement for the subsequent procedure will be denied. You would get paid only once. If you use modifiers appropriately, you would be paid for both visits.

Remember: The documentation and the operative note should include the following:

- Reason for discontinuation of the surgery
- HCPCS code for the intended procedure or any procedures actually carried out
- Supplies actually provided

Time spent in each stage (e.g., pre-operative, operative, and post-operative).

The difference in reimbursement for modifier -73 versus -74 can be significant, so timing and documentation are critical, says **Sarah L. Goodman, MBA, CPC-H, CCP, FCS**, president/CEO and principal consultant at SLG, Inc., headquartered in Raleigh, N.C. "Thorough documentation is critical for coders who report these modifiers and documentation must list why and when the physician cancelled the procedure."

In addition, coders must know that they cannot report procedures terminated prior to anesthesia and before the patient enters the procedure room.

"The patient actually has to be wheeled into the room," Goodman said. "That's why it's key to make sure you have the wheels-in time recorded on the chart."

Many times, documentation lists the procedure start time, but it doesn't always clearly reflect when the patient was wheeled into the procedure room, Goodman adds. . But if the procedure is cancelled prior to anesthesia and the wheels-in time is undocumented or unclear, the coder can't report the code.