# Modifier Coding Alert

## ASC/Hospital Outpatient: Focus on Whether Anesthesia Was Used to Reveal the Correct Modifier

**Bring in 50-100 percent of reimbursements with anesthesia services.**

As an ambulatory surgery center (ASC) or hospital outpatient coder, you have two modifiers to use for the cancellation of procedures  modifiers 73 and 74. Which one you use has everything to do with whether anesthesia is administered or not.

Modifiers 73 (Discontinued out-patient hospital/ambulatory surgery center [ASC] procedure prior to the administration of anesthesia) and 74 (... after administration of anesthesia) have one thing in common: You use both in the facility setting. The difference between modifier 73 and 74 is that you use one before anesthesia is administered and one after. Read on to ensure you choose correctly every time.

**Attach Modifier 73 When Anesthesia Isn't a Factor**

If you are billing for a facility, you will use modifier 73 when a procedure is discontinued prior to anesthesia administration due to an extenuating circumstance or circumstances that threaten the wellbeing of the patient.

You should use modifier 73 "when the patient has been prepped and taken to the room where the procedure is to take place and before anesthesia is administered," explains **Monica Gourley, CCS, HCS-D**, clinic coder at Klickitat Valley Health Services in Goldendale, Wash.

**Example:** "A 65-year-old man is brought to the operating room for repair of a recurrent inguinal hernia," suggests Gourley. "The patient is prepped and positioned and carried out. Before the anesthesia is administered, the patient complains of chest pain, with cardiac monitoring revealing ST segment changes. The procedure is then canceled."

**Code it:** In this case, you would report the procedure using 49520 (Repair recurrent inguinal hernia, any age; reducible) with modifier 73 attached.

You would also use modifier 73 if the patient requests that the procedure be stopped for some reason. For example, if a patient changes his mind about having a procedure and requests that it be canceled you might need modifier 73. If no anesthesia has been administered and if the patient hasn't been taken into the surgical suite, the ASC reports nothing for the intended procedure. If the patient has been taken into the surgical suite but anesthesia has not been administered, the facility technically could report the anticipated procedure code with modifier 73. This situation, however, would be quite rare and would merit case-by-case evaluation before submitting a claim.

"According to Medicare, modifier 73 can be used from the time the patient is in the procedure room until anesthesia (local, regional, or general) has been administered," says **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CPCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Tex.

"This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued," says CMS in the Medicare Claims Processing Manual for ASCs.

**Payment perspective:** "Contractors pay 50 percent of the rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced or the procedure initiated (use modifier 73)," CMS continues. "Facilities use a 73 modifier to indicate that the procedure was terminated prior to induction of anesthesia or initiation of the procedure."

Check with other payers for guidance on reporting and reimbursement of canceled procedures. Some follow the Medicare payment reduction rules; others may be subject to contract terms.

**Report 74 When Notes Reveal Anesthesia Was Started**

When your surgeon stops an ASC or outpatient hospital procedure after anesthesia (either local, regional block[s], moderate sedation/analgesia ["conscious sedation"], deep sedation/analgesia, or general) has been administered, you'll turn to modifier 74.

The reason for the discontinued procedure can be the same as the reason for using modifier 73: a circumstance that threatens the wellbeing of the patient occurs. The situation that may result in the cancellation of the procedure could involve cyanosis, ventricular fibrillation, or arrhythmia, for example.

**Good to know:** Once anesthesia administration begins, the procedure is considered a surgical procedure and the facility will receive full payment.

No matter when the cancellation takes place, "the notes should include at what point the procedure was canceled to verify that it was in fact prior to administration of anesthesia," says Gourley.

**Reporting for Multiple Terminated Planned Procedures**

When one or more procedures are completed, report the procedures as usual. The procedures that aren't started, you don't report.

**Alternative:** "When none of the planned procedures are completed, then the first planned procedure is reported with the modifier 73. The others are not reported. This modifier should be used to cover the expenses involved for the use of the facility," says **M. Lorraine Varlas, CCS-P**, member of Local CMS Carrier (Novitas Solutions) Provider Outreach Education (POE) Advisory Group and compliance auditor for Allegheny Health Network, in Pittsburgh, Pa.

If the provider started the first procedure (scope inserted, intubation started, incision made, etc.) and/or the patient receives anesthesia, you use modifier 74. You don't report the other procedures.

**Warning:** If the first procedure is terminated prior to the induction of anesthesia and before the patient is wheeled into the procedure room, you don't report the procedure. You also cannot report canceled procedures that don't require anesthesia, such as radiology procedures, with modifier 73 or 74.

**Key:** The patient has to be taken to the room where the procedure is to be performed in order to report modifier 73 or 74.

**Be Prepared With Thorough Documentation**

The provider must include some distinct information in his documentation so that it is readily available upon request.

According to Varlas, per the Medicare Claims Processing Manual for ASCs, documentation supporting your addition of modifier 73 or 74 must include the following:

- Reason for termination of surgery
- Services actually performed
- Supplies actually provided
- Services not performed that would have been performed if surgery had not been terminated
- Supplies not provided that would have been provided if the surgery had not been terminated
- Time actually spent in each stage, e.g., pre-operative, operative, and post-operative
- Time that would have been spent in each of these stages if the surgery had not been terminated
- HCPCS code for procedure had the surgery been performed.

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