JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.019
		Effective Date	06/10/2024
		Approval Date	03/27/2024
	Subject **Discontinued Procedures (Modifiers 73 and 74)**	*Supersedes Date*	08/01/2020
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		Page	1 of 5

This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Anesthesia, Discontinued Services, Modifier 73 , Modifier 74

Table of Contents		Page Number

I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory

mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

Modifiers 73 and 74 provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for a procedure and scheduling a room for performing the procedure where the service is subsequently discontinued. This policy applies to for discontinued procedures performed in Ambulatory Surgery Centers (ASCs) and Hospital Outpatient facilities, only. Providers must submit claims on a CMS-1500 or UB-04, or their electronic equivalents, as appropriate. Each line of business possesses its own unique guidelines for benefit and payment purposes, as such JHHP will align with regulatory, state and federal guidance to identify services that are eligible as reimbursable or non-reimbursable, in accordance with the member's plan.

III. POLICY STATEMENT

This policy aligns with CMS guidance and is applicable for both participating and nonparticipating providers, who submit claims to JHHP. JHHP allows reimbursement to both hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) when billed correctly, for discontinued procedures appended with the appropriate modifier. Documentation may be reviewed to determine if the billed procedures meets plan coverage criteria and applicable coding guidelines for the use of modifiers 73 and 74. In the State of Maryland, reimbursement for hospital services by all payers classified as Maryland Waiver Hospitals are based upon the rates as established by the Health Services Cost Review Commission (HSCRC) (COMAR 10.09.06.09(A)(1)). Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

A. Modifiers 73 and 74 are only used to indicate discontinued procedures for which anesthesia is planned or provided, when reported by either a HOPD or ASC.
B. When the provider terminates a surgical/diagnostic procedure after the procedure starts (incision made, intubation started, scope inserted), and after administration of anesthesia (local, regional block or general), the appropriate modifier(s) for anesthesia services must be reported, and in the correct order, or the service will be denied.
C. When another modifier that reduces the fee schedule amount is also applicable, Modifiers 73 and 74 must be reported in the secondary position.
D. Modifiers 73 or 74 can be used on **one** procedure code per member per date of service. If the portion of the procedure that was completed can be represented by another procedure code, JHHC expects the provider to bill for the revised procedure code instead of billing these modifiers.

E. In alignment with CMS guidance, when modifier -73 is appended to a procedure code for services that are discontinued after the patient has been prepared for the procedure and taken to the procedure room but **before anesthesia** is provided will be paid at 50% of the allowed amount. Only the primary intended procedure should be submitted on the claim.

F. In accordance with CMS guidance, when modifier -74 is appended to a procedure for services that are discontinued, partially reduced or canceled **after** the procedure has been initiated and/or the patient has received anesthesia will be paid at 100% of the allowable amount. Only the primary intended procedure should be submitted.

V. INAPPROPRIATE BILLING of MODIFIERS 73 and 74

A. Do not bill modifier 74 for procedures for which anesthesia is **not** planned that are discontinued, partially reduced, or canceled after the patient is prepared and taken to the room where the procedure is to be performed. Modifiers 73 and 74 are not to be reported by physicians or other qualified health care providers.

B. It is only appropriate for the HOPD/ASC to use.

C. Do not use modifiers 73 or 74 when an elective cancelation or postponement of a procedure based on the physician or patient's choice.

D. It is inappropriate to report modifier 74 for the termination of the procedure **prior** to the beginning of the procedure or the administration of anesthesia. Modifier 73 and 74 cannot be combined with Modifier 50.

E. If a bilateral procedure is planned and discontinued before either side is completed, bill the unilateral procedure code with the appropriate modifier. If a bilateral procedure is planned and discontinued after one side is complete, bill the unilateral procedure code.

F. Do not append modifiers 73 and/or 74 to add-on codes.

VI. EXCEPTIONS AND EXCLUSIONS

1. A. Although Outpatient Prospective Payment System (OPPS) exempt facilities and Maryland Waiver Providers are excluded from payment under OPPS, they still must report in accordance with the Healthcare Common Procedure Coding System (HCPCS).

   B. Maryland Waiver Providers are required to bill services in accordance to the Health Services Cost Review Commission (HSCRC) rules and regulations, and will be reimbursed under the HSCRC payment methodology.

   C. **PPMCO:** Billed services applicable to this policy will be reimbursed in accordance to the Maryland Medicaid Administration Professional Services Provider Manual and MDH transmittals. Please consult the authoritative guidance found in the MDH Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

   - JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
   - Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
   - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

   D. **USFHP**: JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

VII. CODES, TERMS and DEFINITIONS

Term	Definition

Ambulatory Surgical Center (ASC)	An ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). A hospital-operated facility has the option of being considered by JHHP either to be an ASC or to be a provider-based department of the hospital as defined in 42 CFR 413.65.
Anesthesia Services	For purpose of this policy, when billing for covered services furnished in the HOPD, anesthesia services include, but are not limited to: local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, general anesthesia, administration of anesthetic.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.

Modifiers

Modifier	Definition
50	Modifier 50 is defined as a bilateral procedure performed on both sides of the body. Services will be denied when a procedure code or modifier reported is inconsistent with the modifier used. ASC specialty providers don't report modifier 50.
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure ***PRIOR*** to the administration of anesthesia. Modifier 73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well-being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia.

74	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure ***AFTER*** administration of anesthesia. Modifier 74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient. This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or canceled at the physician's discretion after the administration of anesthesia.

VIII. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Maryland Department of Health
- Medicare Billing Form CMS-1450 and the 837I Booklet
- Medicare Claims Processing Manual CH. 4- Part B Hospital
- Medicare Claims Processing Manual CH.14 – Ambulatory Surgical Centers
- Medicare Claims Processing Manual CH. 25- Completing and Processing the Form CMS-1450 Data Set
- National Uniform Billing Committee (NUBC)
- TRICARE Reimbursement Manual

IX. APPROVALS

Date	Revision/Review	Reason for Modification	Approved By
3/27/2024	Revision	Policy template, billing guidance, and references updated.	Reimbursement Policy Committee (RPC)