ACTION

☒ New Policy
☐ Repealed Policy Date: _____
☐ Superseded Policy Number: _____

The most current version of the reimbursement policies can be found on www.jhhc.com.

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Johns Hopkins HealthCare (JHHC) benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services must be billed with ICD-10 codes, CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Johns Hopkins HealthCare (JHHC) may:

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

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

POLICY:

Johns Hopkins Healthcare LLC allows reimbursement to hospitals and ambulatory surgical facilities for discontinued procedures when appended with the appropriate modifier

SCOPE:

This policy applies to Ambulatory Surgery Centers (ASCs) and Outpatient Hospital facilities, submitting claims on CMS 1500 or UB-04 claim forms, as appropriate, or their electronic equivalents.

DEFINITIONS:

Discontinued Services – a surgical or diagnostic procedure provided by a physician or other health care professional that was less than usually required for the procedure as defined in the Current Procedural Terminology (CPT®) book.

Modifier 73 – used 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.

Modifier 74 – used 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 cancelled at the physician's discretion after the administration of anesthesia.

PROVIDER BILLING GUIDELINES:

Procedures that are discontinued for elective reasons should not be billed with Modifier 73 or Modifier 74, as JHHC will not reimburse under this circumstance. Elective cancellations include the member not showing, the member's noncompliance, the member deciding not to have the procedure, or rescheduling initiated by either the facility or the member.

Modifier 73 or Modifier 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.

Modifier 73 and Modifier 74 cannot be combined with Modifier 50. 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.

Appropriately billed procedures that are discontinued at the health care professional's direction based on imminent risk to the member from completing the procedure or extenuating circumstances unknown at the start of the procedure that would diminish successful health outcomes will be reimbursed at 60% of the contracted rate for Modifier 73 and 70% of the contracted rate for Modifier 74.

When another modifier that reduces the fee schedule amount is also applicable, Modifier 73 and Modifier 74 must be reported in the secondary position. Modifier 73 and Modifier 74's payment reduction will be applied after the payment reduction indicated by the modifier in the primary position. (Ex: Modifier 1 = 80 and Modifier 2 = 73 will result in reimbursement at 20% of the contracted rate then 60% of the reduced rate).

The use of these modifiers is limited to procedures for which anesthesia is planned. When anesthesia is not planned, providers are to use Modifier 52 instead.

JHHC does not base reimbursement upon medical documentation, but medical documentation must be available upon request to support the use of the modifier. Documentation should include, but is not limited to, reason for termination, percent of procedure performed (supported in detail), and explanation of adverse risk to the member's health outcomes.

EXCLUSIONS

N/A

EXEMPTIONS

N/A

REFERENCES:

CMS, Medicare Claims Processing Manual (Pub. 100-4), Chap. 4, Sect. 20.6.4

CMS, Medicare Claims Processing Manual (Pub. 100-4). Chap.14, Sect. 40.4

Tricare Reimbursement Policy Manual 6010.61-M, April 1, 2015, Chap 13 Sect 3 - Discounting of Surgical and Terminating Procedures, 3.1.5.2.2.1 and 3.1.5.2.2.2

APPROVALS

Reimbursement Policy Committee Date: 7/6/2020

Review/Revision Dates: 6/15/2020