CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 442 **Date: JANUARY 21, 2005**

CHANGE REQUEST 3507

SUBJECT: Hospital Outpatient Prospective Payment System (OPPS): Use of Modifiers -52, -73 and -74 for Reduced or Discontinued Services

I. SUMMARY OF CHANGES: This manual revision clarifies use of modifiers -52, -73, and -74. These modifiers are used to report procedures that are discontinued by the physician due to unforeseen circumstances. Modifier -52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia. For surgeries and certain diagnostic procedures requiring anesthesia (including colonoscopies), the hospital may receive 50 percent of the OPPS payment amount for cases in which the procedure is discontinued after the beneficiary was prepared for the procedure and taken to the room where the procedure was to be performed. If the procedure is discontinued after the beneficiary has received anesthesia or after the procedure was started (e.g., scope inserted, intubation started, incision made) the hospital may receive the full OPPS payment amount for the discontinued procedure. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia.

This manual revision also clarifies that discontinued radiology procedures that do not require anesthesia may not be reported using modifiers -73 and -74.

CLARIFICATION – EFFECTIVE DATE: February 22, 2005
IMPLEMENTATION DATE: February 22, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/20/6/Use of Modifiers
R	4/20/6/6.4 Use of Modifiers for Discontinued Services

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 442	Date: January 21, 2005	Change Request 3507

SUBJECT: Hospital Outpatient Prospective Payment System (OPPS): Use of Modifiers -52, -73, and -74 for Reduced or Discontinued Services

I. GENERAL INFORMATION

A. Background: CMS has received questions about the use of these modifiers that indicate that clarification of our policy is needed.

Policy: This manual revision clarifies use of modifiers -52, -73 and -74. These modifiers are used to report procedures that are discontinued by the physician due to unforeseen circumstances. For billing under the OPPS, modifier -52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia. For surgeries and certain diagnostic procedures requiring anesthesia (including colonoscopies), the hospital may receive 50 percent of the OPPS payment amount for cases in which the procedure is discontinued after the beneficiary was prepared for the procedure and taken to the room where the procedure was to be performed. If the procedure is discontinued after the beneficiary has received anesthesia or after the procedure was started (e.g., scope inserted, intubation started, incision made) the hospital may receive the full OPPS payment amount for the discontinued procedure. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia.

This manual revision also clarifies that discontinued radiology procedures that do not require anesthesia may not be reported using modifiers -73 and -74.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Car r ier	DMERC	F I SS	MCS	VMS	CWF	
3507.1	FIs shall advise their OPPS hospitals to report modifiers -52, -73, -74 for reduced or discontinued services in accordance with Pub. 100.4, Chapter 4, Section 20.6.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 22, 2005 **Implementation Date:** February 22, 2005 **Pre-Implementation Contact(s):** Dana Burley dburley@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**Medicare Contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

20.6 - Use of Modifiers

(Rev. 442, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

The following is a list of all modifiers that are reported under OPPS as of April 1, 2002. Definitions may be found in the current CPT guide or the HCPCS Guide.

Modifiers Used for Outpatient Prospective Payment System

Level I (CPT) Modifiers				Level II (HCPCS) Modifiers							
-25	-50	-73	-91	-CA	-E1	-FA	-GA	-LC	-QL	-RC	-TA
-27	-52	-74			-E2	-F1	-GG	-LD	-QM	-RT	-T1
	-58	-76			-E3	-F2	-GH	-LT			-T2
	-59	-77			-E4	-F3	-GY				-T3
		-78				-F4	-GZ				-T4
		-79				-F5					-T5
						-F6					-T6
						-F7					-T7
						-F8					-T8
						-F9					-T9

As indicated in §20.6.2, modifier -50, while it may be used with diagnostic and radiology procedures as well as with surgical procedures, should be used to report bilateral procedures that are performed at the same operative session as a single line item. Modifiers RT and LT are not used when modifier -50 applies. A bilateral procedure is reported on one line using modifier -50. Modifier -50 applies to any bilateral procedure performed on both sides at the same session.

NOTE: Use of modifiers applies to services/procedures performed on the same calendar day.

Other valid modifiers that are used under other payment methods are still valid and should continue to be reported, e.g., those that are used to report outpatient rehabilitation and ambulance services. Modifiers may be applied to surgical, radiology, and other diagnostic procedures. Providers must use any applicable modifier where appropriate. Providers do not use a modifier if the narrative definition of a code indicates multiple occurrences.

EXAMPLES

The code definition indicates two to four lesions. The code indicates multiple extremities.

Providers do not use a modifier if the narrative definition of a code indicates that the procedure applies to different body parts.

EXAMPLES

Code 11600 (Excision malignant lesion, trunks, arms, or legs; lesion diameter 0.5 cm. or less)

Code 11640 (Excision malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less)

Modifiers -GN, -GO, and -GP must be used to identify the therapist performing speech language therapy, occupational therapy, and physical therapy respectively.

Modifier -50 (bilateral) *applies* to diagnostic, radiolog*ical*, and surgical procedures.

Modifier -52 applies to radiological procedures.

Modifiers -73, and -74 apply only to *certain diagnostic and* surgical procedures *that require anesthesia*.

Following are some general guidelines for using modifiers. They are in the form of questions to be considered. If the answer to any of the following questions is yes, it is appropriate to use the applicable modifier.

1 - Will the modifier add more information regarding the anatomic site of the procedure?

EXAMPLE

Cataract surgery on the right or left eye.

2 - Will the modifier help to eliminate the appearance of duplicate billing?

EXAMPLES

Use modifier 77 to report the same procedure performed more than once on the same date of service but at different encounters.

Use modifier 25 to report significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

Use modifier 58 to report staged or related procedure or service by the same physician during the postoperative period.

Use modifier 78 to report a return to the operating room for a related procedure during the postoperative period.

Use modifier 79 to report an unrelated procedure or service by the same physician during the postoperative period.

3 - Would a modifier help to eliminate the appearance of unbundling?

EXAMPLE:

CPT codes 90780 (Infusion therapy, using other than chemotherapeutic drugs, per visit) and 36000 (Introduction of needle or intra catheter, vein): If procedure 36000 was performed for a reason other than as part of the IV infusion, modifier -59 would be appropriate.

20.6.4 - Use of Modifiers for Discontinued Services

(Rev. 442, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

A - General

Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers.

Modifier -73 is used by the facility to indicate that a surgical or diagnostic 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. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, or general anesthesia. 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. Prior to January 1, 1999, modifier -52 was used for reporting these discontinued services.

Modifier -74 is used by the facility to indicate that a surgical or diagnostic 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. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia. This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion. Prior to January 1, 1999, modifier -53 was used for reporting these discontinued services.

Modifiers -52 and -53 are no longer accepted as modifiers for certain diagnostic and surgical procedures under the hospital outpatient prospective payment system. Coinciding with the addition of the modifiers -73 and -74, modifiers -52 and -53 were revised. Modifier -52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier -53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.

The elective cancellation of a procedure should not be reported.

Modifiers -73 and -74 are used to indicate discontinued surgical and certain diagnostic procedures only. They are **not** used to indicate discontinued radiology procedures.

B – *Effect* on Payment

Surgical or certain diagnostic procedures that are discontinued after the patient has been prepared for the procedure and taken to the procedure room for which modifier -73 is coded, will be paid at 50 percent of the full OPPS payment amount.

Surgical or certain diagnostic procedures that are discontinued after the procedure has been initiated and/or the patient has received anesthesia for which modifier -74 is coded, will be paid at the full OPPS payment amount.

C - Termination Where Multiple Procedures Planned

When one or more of the procedures planned is completed, the completed procedures are reported as usual.

When one or more of the procedures planned is completed, the completed procedures are reported as usual. The other(s) that were planned, and not started, are not reported. When none of the procedures that were planned are completed, *and the patient has been prepared and taken to the procedure room,* the first procedure that was planned, *but not completed* is reported with modifier -73. *If the first procedure has been started (scope inserted, intubation started, incision made, etc.) and/or the patient has received anesthesia,* modifier -74 *is used. The other procedures are not reported.*

If *the first* procedure is terminated prior to the induction of anesthesia and before the patient is wheeled into the procedure room, the procedure should not be reported. The patient has to be taken to the room where the procedure is to be performed in order to report modifier -73 or -74.