PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

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Title	**Modifier 74-Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure after Administration of Anesthesia**		
Number	**CP.PP.146.v2.9**		
Last Approval Date	11/12/24	**Original Effective Date**	10/01/04
Cross Reference	• *Modifier 53 –Discontinued Procedure* • *Modifier 73 – Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with Modifier 74 that are submitted on a CMS 1450 paper claim or 837I electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.

Policy	The Plan recognizes Modifier 74- *Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure after Administration of Anesthesia* when appended to a service to indicate that due to extenuating circumstances or those that threaten the well being of the patient, a surgical or diagnostic procedure that requires anesthesia at an outpatient hospital or ambulatory surgical center (ASC) was discontinued **after** the administration of anesthesia or after the procedure was started (incision made, intubation started, etc.). Anesthesia includes local blocks, regional blocks, moderate sedation, deep sedation, or general anesthesia. Append modifier 74 to the ASC or outpatient **facility** surgical procedure code that was discontinued **after** the administration of anesthesia or start of the procedure. Documentation in the medical records must indicate why and when the physician decided to cancel the procedure, services and supplies that were/were not rendered, and time spent preoperatively, operatively, and post-operatively. Modifier 74 is appended to a discontinued ASC or outpatient **facility** service when billed on a facility claim form. Modifier 74 must not be appended to a procedure code in conjunction with the following: • **any** ASC or outpatient facility procedure that was **electively** discontinued by the patient or physician • unlisted procedure codes • add-on procedure codes • professional services, or • prior to the administration of anesthesia Modifier 73- *Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia* is appended to a discontinued ASC or outpatient **facility** service **prior to** the administration of anesthesia or before the start of the surgical procedure when billed on a facility claim form. Modifier 53-*Discontinued Procedure* should not be appended to any discontinued **ASC or outpatient facility service** as modifier 53 is only appended to professional services.

Violations of Policy	Violations of this policy by any party that enters a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None
References	• American Medical Association's Current Procedural Terminology (AMA/CPT) codebook • Centers for Medicare and Medicaid Services (CMS), Publication 100-04,

	○ Chapter 4-Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 20.6.4 ○ Chapter 14-Ambulatory Surgical Centers, Section 40.4

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	11/12/24; 02/05/24; 03/13/23; 04/08/22; 08/02/21; 08/17/20; 10/11/19; 10/18/18; 12/04/17; 12/12/16; 01/08/16; 01/11/15; 01/12/14; 01/13/13; 01/26/12; 01/27/11; 03/04/10; 05/11/09; 07/21/08; 06/09/07; 05/05/06; 08/29/05; 10/21/04	
Version History	10/18/18	Annual Review; no changes
	10/11/19	• Clarified the kinds of applicable anesthesia in the first paragraph. • In the second paragraph, it indicated that a rationale for the discontinuation of the procedure must be present in the medical records.
	08/17/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms
	08/02/21	• Clarified in the first paragraph that modifier 74 is applicable to surgical procedures that require anesthesia. • Identified the various kinds of anesthesia that could be performed. • Added additional information on documentation in the patient's medical record is needed to support the use of modifier 74.
	04/08/22	Added clarification on the correct use of modifiers 74, 73 and 53 for discontinued services.
	03/13/23	Annual review; no changes
	02/05/24	In the Policy section, added the fifth paragraph with bulleted examples of when appending modifier 74 to a service is not appropriate.
	11/12/24	Annual review; no changes

This policy was published on November 15, 2024