

Surgical Modifiers

Introduction

Purpose

The purpose of this module is to provide participants with an understanding of the policies and procedures of surgical modifiers for professional services. This module includes detailed information about correct billing practices and Medi-Cal reimbursement policy.

Module Objectives

- Explain the use of modifiers in the Medi-Cal program
- Demonstrate the correct placement of modifiers on the claim forms
- Examine claim examples
- Review surgical procedure modifiers
- Identify pre-operative and post-operative services policy
- Identify modifiers for Non-Physician Medical Practitioners (NMPs)
- Provide general information regarding anesthesia-related drug and supply modifiers
- Explain “By Report” documentation

Acronyms

A list of current acronyms is located in the Appendix section of each complete workbook.

Description

The use of modifiers is an integral part of billing for health care services. Modifiers give additional information for claims processing. The following modifiers are discussed in this training module:

- Conventional Surgical Modifiers: AG, 50, 51, 80 and 99
- Additional Surgical Modifiers:

Table of Additional Surgical Modifiers

Type of Practice	Surgical Modifier
Anesthesia-related Drugs & Supplies	UA, UB
Evaluation and Management	24, 25, 57
General Use	22, 52, 53, 54, 55, 58, 62, 66, 73, 74, 78, 79, 99
Non-Physician Medical Practitioner	AS, SA, SB, U7, U9

Surgical Procedures Require Modifiers

All surgical procedure codes require a modifier. Failure to submit a modifier with a surgical procedure code will result in the claim being returned to the provider for correction.

The inappropriate use of a modifier, or using a modifier when it is not necessary, will result in a denial or delay in payment. All modifiers and procedure codes must be appropriate for the diagnosis code listed.

B Surgical Modifiers
Page updated: March 2023

Modifier Placement on Claim Form

Modifier placement location appear as “XX.” See claim form examples below:

24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To				CPT/HCPCS	MODIFIER					
MM	DD	YY	MM	DD	YY						
02	01	23				Procedure XX				NPI	
						Code				NPI	

Sample: Partial CMS-1500 Claim Form

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
	DESCRIPTION	Procedure Code XX	020123		

Sample: Partial UB-04 Claim Form

Primary Surgeon or Podiatrist Modifier AG

The primary surgeon or podiatrist is required to use modifier AG on the only or highest valued surgical procedure code (HCPCS Z1200 thru Z1212 and CPT series 10000 thru 69999) being billed for the date of service.

Multiple Primary Surgeons

Two or more surgeons can use modifier AG for the same patient on the same date of service if the procedures are performed independently and in different specialty areas. This does not include surgical teams or surgeons performing a single procedure requiring different skills. An explanation of the clinical situation and operative reports by all surgeons involved must be included with the claim.

if the procedures are performed independently and in a different anatomical area or compartment. All claims must include:

- Medical justification
- Operative reports by all surgeons involved
- Clearly indicated start and stop times for each procedure

B Surgical Modifiers

Page updated: March 2023

Multiple Surgical Procedure Policy Exceptions

The following medical policies have been established for specific, multiple surgeries when billed for a recipient, by the same provider, for the same date of service.

- Tubal ligations performed at the time of a cesarean section or other intra-abdominal surgery are reimbursable only when billed with CPT code 58611. For more information, refer to the Hysterectomy (hyst) and Sterilization (ster) sections in the appropriate Part 2 manuals
- A salpingectomy or oophorectomy (CPT codes 58700, 58720, 58900 through 58943) billed on the same date of service as a hysterectomy (CPT codes 58150 through 58285) is not separately reimbursable
- A vaginal delivery (CPT codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT codes 59510, 59514, 59618 or 59620) is not reimbursable unless the claim indicates a multiple pregnancy – one child delivered vaginally and one by cesarean section
- Intra-ocular lens with cataract surgery policy is located in the Surgery: Eye and Ocular Adnexa (surg eye) section of the appropriate Part 2 provider manual.
- Insertion of a non-indwelling or temporary indwelling bladder catheter (CPT codes 51701 and 51702) is not separately reimbursable when billed with CPT codes 10021 through 69979
- CPT code 36000 (introduction of needle or intracatheter, vein) is not reimbursable when billed by same provider for the same recipient on the same date of service with any CPT code within the ranges of 00100 through 69999 and 96360 through 96549

Separate Operative Sessions on Same Date of Service Modifier AG

Duplicate billing for surgical services is not reimbursable. Occasionally separate surgical services may be performed during different operative sessions, by the same or a different surgeon, for the same recipient and date of service. Providers must use modifier AG to obtain full reimbursement for both primary procedures and document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim that the procedures were performed at **different times of the day**.

Increased Procedural Services Modifier 22

Modifier 22 may be billed when the work required to provide a service is substantially greater than typically required and may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work.

Examples of procedures involving significant increased operative complexity and/or time in a significantly altered surgical field can include:

- Prior surgery
- Distorted anatomy
- Irradiation
- Marked scarring
- Adhesions
- Infections
- Very low weight
- Inflammation

When the service provided is greater than usually required for the listed procedure, requiring the use of modifiers 22 and AG, use modifier 99 with an explanation in the *Remarks* field (Box 80) on *UB-04* claims and Additional Claim Information field (Box 19) on *CMS-1500* claims. Indicate that the procedure performed required the use of both modifiers (99 = AG + 22). Justification is required on the claim.

Assistant Surgeon Modifier 80 and 99

Assistant surgeons must use modifier 80 as a part of each procedure billed. The major surgical procedure is identified by the use of modifier 80 (assistant surgeon) and multiple surgical procedures identified by the use of modifier 99 (multiple modifiers).

Include an explanation in the *Remarks field* (Box 80)/*Additional Claim Information field* (Box 19) of the claim for the modifiers that apply to each procedure. Assistant Surgeons must not bill multiple procedures with modifier 51 or the claim will deny.

Note: Not all surgical procedures are reimbursable to an assistant surgeon. To determine if there are any policy restrictions, refer to the TAR and Non-Benefit List: Codes (tar and non cd) section in the appropriate Part 2 provider manual.

B Surgical Modifiers

Page updated: March 2023

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) LINE 1: BUIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT MODIFIER 99 = MODIFIER 80 + 50. LINE 3: EXCISION OF LESION MODIFIER 99 = MODIFIERS 80 + 51.										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE		ORIGINAL REF. NO.					
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. E/PSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From To			SERVICE			CPT/HCPCS			MODIFIER								
02 01 23			21			28292			80			32 71	1		NPI		
02 01 23			21			28292			99			32 71	1		NPI		
02 01 23			21			28090			99			32 28	1		NPI		

Sample: Partial CMS-1500 claim form Modifier 80 and 99

42 REV. CD.		43 DESCRIPTION			44 HCPCS / RATE / HIPPS CODE			45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES	
		BUNIONECTOMY, RT FOOT			2829080			020123		1			
		BUNIONECTOMY, LT FOOT			2829099			020123		1			
		EXCISION OF LESION			2809099			020123		1			

68 CX		D1D1D1D		D2D2D2D																69	
69 ADMIT DX		70 PATIENT REASON DX																		73	
74 PRINCIPAL PROCEDURE CODE		9. OTHER PROCEDURE CODE		10. OTHER PROCEDURE CODE		75		76 ATTENDING NPI		1234567890		QUAL									
								LAST				FIRST									
74 OTHER PROCEDURE CODE		9. OTHER PROCEDURE CODE		10. OTHER PROCEDURE CODE		75		77 OPERATING NPI		2345678901		QUAL									
								LAST				FIRST									
80 REMARKS		81CC						78 OTHER NPI				QUAL									
LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT MODIFIER 99 = MODIFIERS 80 + 50. LINE 3: EXCISION OF LESION MODIFIER 99 = MODIFIERS 80 + 51		a						LAST				FIRST									
		b						79 OTHER NPI				QUAL									
		c						LAST				FIRST									
		d						LAST				FIRST									

Sample: Partial UB-04 claim form Modifier 80 and 99

B Surgical Modifiers
Page updated: March 2023

Bilateral Procedure Modifier 50

Providers use modifier 50 when bilateral procedures add significant time or complexity to patient care at a single operative session. To use modifier 50, providers identify the first procedure by its listed procedure code with modifier AG for the primary surgeon. Bilateral procedures requiring a separate incision performed at the same operative session, providers should bill the second procedure on the next billing line with the appropriate CPT code followed by modifier 50, which indicates the procedure was performed bilaterally.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT.										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. D1D1D1D B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02 01 23			21		28290 AG					161.71		1		NPI	
02 01 23			21		28290 50					161.71		1		NPI	
														NPI	
														NPI	

Sample: Partial CMS-1500 Bilateral Modifier 50

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
	BUNIONECTOMY, RT FOOT	28290AG	020123	1	
	BUNIONECTOMY, LT FOOT	2829050	020123	1	

00 01 D1D1D1D	A	B	C	D	E	F	G	H	68			
0	I	J	K	L	M	N	O	P	Q			
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73		
74 PRINCIPAL PROCEDURE CODE	DATE	a	OTHER PROCEDURE CODE	DATE	b	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI	1234567890	QUAL	
									LAST		FIRST	
c	OTHER PROCEDURE CODE	DATE	d	OTHER PROCEDURE CODE	DATE	e	OTHER PROCEDURE CODE	DATE	77 OPERATING NPI	2345678901	QUAL	
									LAST		FIRST	
80 REMARKS	B1CC	a	b	c	d				78 OTHER NPI		QUAL	
LINE 1: BUNIONECTOMY, RT FOOT									LAST		FIRST	
LINE 2: BUNIONECTOMY, LT FOOT									79 OTHER NPI		QUAL	
									LAST		FIRST	

Sample: Partial UB-04 Bilateral Modifier 50

B Surgical Modifiers

Page updated: March 2023

Multiple Bilateral Procedures

When billing for multiple bilateral procedures performed by the same physician at the same operative session, providers must use modifiers **AG, 50, 51 and 99**. In this example, three bilateral procedures are performed on the patient's eyes and nose by the same physician during the same operative session.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) LINE 4: MODIFIER 99 = MODIFIERS 50 + 51. SEE ATTACHMENT.										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
02	01	23			21		68720	AG			161 71	1		NPI	
02	01	23			21		68720	50			161 71	1		NPI	
02	01	23			21		31200	51			121 28	1		NPI	
02	01	23			21		31200	99			121 28	1		NPI	
														NPI	
														NPI	

Sample: Partial CMS-1500 Multiple Modifiers AG, 50, 51, and 99

B Surgical Modifiers

Page updated: March 2023

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555										2		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL 831											
6 PATIENT NAME a DOE, JANE					9 PATIENT ADDRESS a					5 FED. TAX NO.		8 STATEMENT COVERS PERIOD FROM THROUGH		7											
10 BIRTHDATE 08231980		11 SEX F	12 DATE		13 HR		14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28 29 ACCT STATE		30								
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE		36 OCCURRENCE DATE		37 OCCURRENCE SPAN FROM THROUGH		38 OCCURRENCE SPAN FROM THROUGH		37									
36										39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT											
42 REV. CD.										43 DESCRIPTION		44 HCPCS / RATE / HIPP'S CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
										DACRYOCYSTORHINOSTOMY		68720AG		020123		1		161 71							
										DACRYOCYSTORHINOSTOMY		6872050		020123		1		161 71							
										ETHMOIDECTOMY		3120051		020123		1		121 28							
										ETHMOIDECTOMY		3120099		020123		1		121 28							
50 PAYER NAME O/P MEDI-CAL					51 HEALTH PLAN ID					52 PLAN INFO		53 PLAN BR.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 76598		56 NPI		0123456789					
58 INSURED'S NAME					59 REL.					60 INSURED'S UNIQUE ID 90000000A95001					61 GROUP NAME		62 INSURANCE GROUP NO.								
63 TREATMENT AUTHORIZATION CODES					64 DOCUMENT CONTROL NUMBER					65 EMPLOYER NAME															
68 D1D1D1D		68 D2D2D2D		B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	48					
69 ADMIT DX		70 PATIENT REASON DX		71 PRINCIPAL PROCEDURE CODE		72 OTHER PROCEDURE CODE		73 PRINCIPAL PROCEDURE DATE		74 OTHER PROCEDURE DATE		75 PRINCIPAL PROCEDURE CODE		76 OTHER PROCEDURE CODE		77 ATTENDING NPI		1234567890		QUAL					
																LAST				F/PST					
																77 OPERATING NPI		2345678901		QUAL					
																LAST				F/PST					
																78 OTHER NPI				QUAL					
																LAST				F/PST					
																79 OTHER NPI				QUAL					
																LAST				F/PST					
80 REMARKS LINE 4: MODIFIER 99 = MODIFIERS 50 + 51. SEE ATTACHMENT.										81 CC		a		b		c		d							

Sample: Partial UB-04 Multiple Modifiers AG, 50, 51, and 99

Multiple Procedures Same Operative Session

When multiple procedures are performed at the same operative session, providers should identify the major procedure with modifier-AG, and identify the secondary, additional or lesser procedures by adding modifier -51 to the secondary procedure codes. The procedure code identified with modifier AG is paid at 100 percent of the Medi-Cal reimbursement rate. The procedure code(s) identified with modifier-51 will generally be paid at 50 percent of the Medi-Cal reimbursement rate.

The following example illustrates the standard reimbursement rule for multiple procedures when performed during the same operative session and billed with modifier 51.

Table of Reimbursement Formulas

CPT Code/Modifier	Reimbursement Formula
41150 AG	100 percent of full-fee rate
38720 51	50 percent of full-fee rate
15120 51	50 percent of full-fee rate
31600 51	50 percent of full-fee rate

Billing Multiple Modifiers

When two or more modifiers are necessary to completely delineate a service, use modifier 99 with the appropriate procedure code and explain the applicable modifiers in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.

For example: when a major surgical procedure is to be performed requiring the use of modifier 22 and modifier AG, use modifier 99 with an explanation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) indicating that the procedure required the use of both modifiers 22 and AG.

National Correct Coding Initiative

A few of surgical procedures are subject to National Correct Coding Initiative (NCCI) edits. To process correctly, claims submitted for multiple surgical procedures on the same day may require addition of an NCCI-associated modifier. For more information, refer to the *Correct Coding Initiative: National* section in the appropriate Part 2 provider manual for instructions regarding the use of NCCI-associated modifiers.

Modifiers Used for Third and Subsequent Procedures

Modifier 99 is used to indicate third and subsequent identical procedures. Modifier 51 is appropriate to indicate a second and third subsequent different procedures. If modifier 51 is used more than once to bill the same procedure code, it will appear to be a duplication.

B Surgical Modifiers

Page updated: March 2023

Multiple Surgical Procedures Reimbursed at 100 Percent

Certain procedures billed by the primary surgeon with modifier 51 are exempt from the multiple procedure reduction rule and are paid at 100 percent of the Medi-Cal Maximum Allowable. For a list of exempt procedures refer to the *Surgery: Billing with Modifiers* (surg bil mod) section in the Part 2 provider manual.

Add-on Codes

Codes with “each additional” in the descriptor should **not** be billed with modifier 99 when performed on the same day or at the same operative session as another surgery. Modifier 51 must be used and indicate a “1” in the *Days or Units* field (Box 24G) on the *CMS-1500* claim form or *Serv.Units* field (Box 46) on the *UB-04* claim form. Add-on codes are commonly used to report such things as skin grafts, or multiple lesions performed on the same date of service.

When completing claim form for both the *CMS-1500* and *UB-04*, providers may use (Box 24G) or (Box 46) and indicate the number of times the “each additional” add-on-code was performed. Billing in this format simplifies the claim form completion. The option to bill “1” on each claim line is also an acceptable billing option.

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To					CPT/HCPCS	MODIFIER						
MM	DD	YY	MM	DD	YY								
02	01	23				15002	AG		425 00	1		NPI	
02	01	23				15003	51		200 00	1		NPI	
02	01	23				15003	51		200 00	1		NPI	
02	01	23				15003	51		200 00	1		NPI	

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To					CPT/HCPCS	MODIFIER						
MM	DD	YY	MM	DD	YY								
02	01	23				15002	AG		425 00	1		NPI	
02	01	23				15003	51		600 00	3		NPI	

Sample: Partial *CMS-1500* “Add-On” Codes Billing Options

B Surgical Modifiers

Page updated: March 2023

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
		15002AG	020123	1	425 00
		1500351	020123	1	200 00
		1500351	020123	1	200 00
		1500251	020123	1	200 00
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
		15002AG	020123	1	425 00
		1500351	020123	1	600 00

Sample: Partial UB-04 “Add-On” Codes Billing Options

Surgical Team Modifier 66

Although the CPT instructions for modifier 66 (surgical team) permit each physician member of a surgical team to report his/her participation separately from the other physician members for billing Medi-Cal. The services of all physician members of a surgical team, including primary and assistant surgeons, must be billed on a single line of one claim for using the appropriate CPT code with modifier 66.

Exception: Anesthesiologist should submit a separate claim using the appropriate five-digit anesthesia procedure code and modifier.

Two Surgeons Modifier 62

Identifies a surgical procedure that requires two surgeons that perform on distinct parts of a procedure.

Note: Each surgeon would bill with modifier 62.

Operative and Postoperative Modifiers and Descriptions

Reduced Services Modifier 52

For use with surgery codes: 66820, 66821, 66830, 66840, 66850, 66920, 66930, 66940 and 66982 through 66985. Requires "By Report" documentation.

Operative Postoperative Management Modifier 54

Surgical care only

Operative Postoperative Management Modifier 55

Postoperative management only

Staged or Related Procedure Postoperative Period Modifier 58

May be used with CPT codes 15002 through 15429 and 52601 to address subsequent part(s) of a staged procedure.

Return to Operating Room Modifier 78

Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period.

Return to Operating Room Modifier 79

Unrelated procedure or service by the same physician during the postoperative period.

Knowledge Review

1. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on December 10, 2022. The cone biopsy was performed on December 17, 2022. What modifier should be used for the cone biopsy? _____.
2. An exploratory laparotomy was performed due to a gunshot wound. A few hours later the patient’s blood pressure drops, and the patient is urgently taken back to the operating room to reopen and explore for possible leakage from the surgical site. What modifier should be used for the reopen/explorative procedure? _____.

See the Appendix for the [Answer Key](#)

Discontinued Procedure Modifiers and Descriptions

If a procedure requires to be discontinued prior to the surgery and administration of anesthesia, it will require “By Report” documentation.

Table of Discontinued Procedure Modifiers and Descriptions

Modifier	Description
53	Discontinued procedure; requires “By Report” documentation
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure <u>prior</u> to the administration of anesthesia; to be reported by hospital outpatient department or surgical clinic only. Requires “By Report” documentation
74	Discontinued outpatient hospital/ambulatory surgery center (ASC) <u>after</u> administration of anesthesia; to be reported by hospital outpatient department or surgical clinic only. Requires “By Report” documentation

Transgender and Gender Diverse Services

Treatment for gender dysphoria is a covered Medi-Cal benefit when medically necessary. Requests for services should be from specialists experienced in providing care to transgender individuals and should use nationally recognized guidelines.

Medically necessary covered services are those services that “are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury” (Title 22, *California Code of Regulations* [CCR], Section 51303).

Note: A service or the frequency of services available to a transgender beneficiary cannot be categorically limited. All medically necessary services must be provided timely. Limitations and exclusions, medical necessity determinations and/or appropriate utilization management criteria that are non-discriminatory may be applied.

For additional billing guidelines, refer to the *Transgender and Gender Diverse Services* (transgender) section of the appropriate Part 2 provider manual.

Evaluation and Management (E&M) Modifiers

Policy for Preoperative Visits Before or on the Day of Surgery

Under most circumstances, including ordinary referrals, the preoperative examination by the operating surgeon or assistant surgeon in the emergency room, hospital or elsewhere on the day of surgery, or one day prior to the day of surgery, is considered a part of the surgical procedure and is not separately reimbursable by Medi-Cal.

Billing exceptions to this policy may be made when the preoperative visit is an initial emergency visit requiring extended evaluation or detention (for example, to prepare the patient or establish the need for the surgery).

Procedures (for example, bronchoscopy prior to thoracic surgery) that are not normally an integral part of the basic surgical procedure may be reimbursed separately.

Policy for Postoperative Visits

Office visits, hospital visits, consultations and ophthalmological exams related to a surgery and billed during a follow-up period of the surgery, are not separately reimbursable if billed by the surgeon or assistant surgeon. These claims will be denied with RAD code 0074 because this service is included in the surgical fee.

Overriding Justification Modifiers

Billing CPT codes 99091 and 99202 thru 99499 (E&M services) with modifier 24, 25, or 57 overrides the requirement of documenting medical justification when billed in conjunction with a surgical procedure as follows:

Modifier	Description
24	Unrelated E&M service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service
57	Decision for surgery (major surgery only, day before or day of procedure)

Non-Physician Medical Practitioner (NMP)

Non-Physician Medical Practitioners (NMPs) include:

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- Licensed Midwife (LM)

Modifier and Description for Non-Physician Medical Practitioners

Modifier	Description
AS	Physician assistant, nurse practitioner or clinical nurse specialist services for assistant at surgery. Certified nurse midwives (CNM) may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by a licensed physician and surgeon
SA	Nurse practitioner rendering service in collaboration with a physician
SB	Nurse midwife. Used when Certified Nurse Midwife service is billed by a physician, hospital outpatient department or organized outpatient clinic (not by CNM billing under his or her own provider number)
U7	Used to denote services rendered by Physician Assistant (PA)
U9	Used to denote services rendered by Licensed Midwife (LM)

Billing Information

Reimbursement for services rendered by an NMP can only be made to the employing physician, organized outpatient clinic or hospital outpatient department. Separate reimbursement is not made for physician supervision of an NMP.

Note: Exceptions to this policy would be for a Certified Nurse Practitioner (CNP) or Certified Nurse Midwife (CNM) enrolled as an independent Medi-Cal provider or a Licensed Midwife.

The following items need to be included on claim forms for reimbursement:

- The NMP’s NPI must be noted in the *Remarks* field (Box 80) on *UB-04* claims or *Additional Claim Information* field (Box 19) on *CMS-1500* claims.
- When billing for assistant surgeon services performed by the PA, services must be billed with modifier 99 (multiple modifiers). (99 = 80 + U7).

Note: Surgical codes that are reimbursable for NMP services can be found in the *Non-Physician Medical Practitioners* (NMP) section (non ph) of the Part 2 provider manual.

B Surgical Modifiers
Page updated: March 2023

Non-Physician Medical Practitioner Claim Examples

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) JANE SMITH, CNM, NPI 1234567890										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ A. D1D1D1D B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER MM DD YY MM DD YY CPT/HCPCS MODIFIER										23. PRIOR AUTHORIZATION NUMBER	
02 01 23 11 57452 SB										F. \$ CHARGES 275 00 G. DAYS OR UNITS 1 H. EPSDT Family Plan I. ID. QUAL NPI J. RENDERING PROVIDER ID. # 1098765432	
										NPI	
										NPI	
										NPI	
										NPI	

Sample: Partial CMS-1500 Claim Form

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / ICD-9 CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	COLPOSCOPY	57452SA	021122	1	275 00		
PAGE OF		CREATION DATE		TOTALS			
50 PAYER NAME		51 HEALTH PLAN ID	52 FILL INFO	53 A09 BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
							57 OTHER PRV ID
58 INSURED'S NAME		59 PREL	60 INSURED'S UNIQUE ID		61 GROUP NAME	62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		
66 DX	D1D1D1D	A	B	C	D	E	F
67	0	J	K	L	M	N	O
68 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 ICD CODE	72 EQ	73
74 PRINCIPAL PROCEDURE CODE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE DATE	OTHER PROCEDURE DATE	75	76 ATTENDING NPI 0123456789 QUAL	
						LAST FIRST	
c	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE DATE	OTHER PROCEDURE DATE		77 OPERATING NPI QUAL	
						LAST FIRST	
80 REMARKS		81 CC				78 OTHER NPI QUAL	
JANE SMITH, NP, NPI 1234567890		a				LAST FIRST	
		b				79 OTHER NPI QUAL	
		c				LAST FIRST	
		d				LAST FIRST	

Sample: Partial UB-04 Claim Form

B Surgical Modifiers

Page updated: September 2020

Anesthesia-Related Drugs and Supplies Modifiers

Table of Anesthesia-Related Drugs and Supplies Modifiers

Modifier	Description
UA	Used for surgical or non-general anesthesia-related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code.
UB	Used for surgical or general anesthesia-related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code.

Billing Reminders

- Modifiers UA and UB are mutually exclusive; therefore, only one modifier is allowed for each surgical procedure.
- Modifiers UA and UB do not conflict with the use of other required modifiers. Modifiers AG or 80 may be used on separate lines with UA or UB on the same claim form.
- Do not attach an itemized list of supplies to the claim.
- Surgical procedures with modifier UA or UB performed more than once on the same day to the same recipient by the same or different provider(s) require additional documentation.

By Report Documentation

The following is a list of Medi-Cal services that require attachments:

- Anesthesia time
- “By Report” procedures/modifiers
- Delay Reason Code used on claim
- Denials from Other Health Coverage (OHC) carriers
- Emergency Statement required
- Medicare Non-Covered or Denied services
- Multiple modifiers
- No price is listed
- Specific surgical procedures
- Sterilization or hysterectomy
- Unlisted injections
- Unlisted services (for example, CPT 36299)
 - No specific CPT description of service
 - Requires a TAR
 - Time involved
 - Nature and purpose of procedure
 - Relation to diagnosis
- Unusual/Complicated procedures

“By Report” Documentation Requirements

The Medical Review Unit is unable to process “By Report” claims without the following information on the attachment:

- Patient’s name
- Date of service
- Procedure code
- Operative report and operating time, or procedure report. Each report must include a description of the actual procedure performed and the results of the procedure. *Pro forma* or “canned” reports are unacceptable.
- Estimated follow-up days required
- Size, number and location of lesions (if applicable)
- When billing unlisted “By Report” procedures (no specific description of service), also state the time involved, the nature and purpose of the procedure or service and how it relates to diagnosis.

Note: “By Report” claim submissions do not always require an attachment. For some procedures, entering information in the *Remarks* field (Box 80) for *UB-04* claims and *Additional Claim Information* field (Box 19) for *CMS-1500* claims may be sufficient.

Learning Activity

Modifier Review

1. An assistant surgeon was involved in performing the procedure. What modifier should be used to bill for the assistant's services?
 - a. 99
 - b. 80
 - c. U7
2. Surgical procedures that require two surgeons who perform on distinct anatomical regions on the same recipient, same date of service, may each bill with modifier AG on separate claims.
 - a. True
 - b. False
3. Procedures billed with modifier 51 are reimbursed at what percentage of the Medi-Cal maximum allowable?
 - a. 50%
 - b. 100%
4. Is it possible to bill with more than one primary surgical procedure with modifier AG on the same date of service?
 - c. Yes
 - d. No
5. When billing for Physician Assistant (PA), what modifier should be used?
 - a. U7
 - b. 80
 - c. 99 = (U7 + 80)
 - d. None

See the Appendix for the [Answer Key](#).

Resource Information

References

The following reference materials provide Medi-Cal billing and policy information.

Provider Manual References

Part 2

Anesthesia (anest)

CMS-1500 Special Billing Instructions (cms spec)

Correct Coding Initiative: National (correct)

Correct Coding Initiative: National – Claim Preparation (correct cod)

Hysterectomy (hyst)

Modifiers: Approved List (modif app)

Non-Physician Medical Practitioners (NMP) (non ph)

Non-Physician Medical Practitioner (NMP) Billing Example: CMS-1500 (non ph cms)

Non-Physician Medical Practitioner (NMP) Billing Example: UB-04 (non ph ub)

Sterilization (ster)

Supplies and Drugs (supp drug)

Surgery (surg)

Surgery Billing Examples: CMS 1500 (surg bil cms)

Surgery Billing Examples: UB-04 (surg bil ub)

Surgery: Billing with Modifiers (surg bil mod)

UB-04 Special Billing Instructions for Inpatient Services (ub spec ip)

UB-04 Special Billing Instructions for Outpatient Services (ub spec op)

Module B Answer Key

Knowledge Review 1

Question 1: A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 1, 2023. The cone biopsy was performed on February 17, 2023. What modifier should be used for the cone biopsy? _____

Answer 1: **79**

Question 2: An exploratory laparotomy was performed due to a gunshot wound. A few hours later the patient's blood pressure drops, and the patient is urgently taken back to the operating room to reopen and explore for possible leakage from the surgical site. What modifier should be used for the reopen/explorative procedure? _____

Answer 2: **78**

Knowledge Review 2

Question 1: An assistant surgeon was involved in performing the procedure. What modifier should be used to bill for the assistant's services?

Answer 1:

- b. **80**

Question 2: Surgical procedures that require two surgeons who perform on distinct anatomical regions on the same recipient, same date of service, may each bill with modifier AG on separate claims.

Answer 2:

- a. **True**

Question 3: At what percentage of the Medi-Cal maximum allowable do multiple procedures billed with modifier 51 get reimbursed?

Answer 3:

- c. **50 percent**

Question 4: Is it possible to bill with more than one primary surgical procedure with modifier AG on the same date of service?

Answer 4:

- a. **Yes**

Question 5: When billing for Physician Assistant (PA), what modifier should be used?

Answer 5:

- a. **U7**