Surgery: Billing with Modifiers

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This section includes instructions for correctly using modifiers on claims for surgical services. For additional help, refer to the *Surgery Billing Examples* section of this manual.

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.

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. (Refer to the *Surgery Billing Examples* section in this manual for an illustrated sample.)

Note: This does not include codes that require split-bill modifiers.

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.

Separate Operative Sessions on Same Date of Service

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 (for example, increased intensity, time, technical difficulty of procedure, and severity of patient's condition where physical and mental effort is required).

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. Identify the bilateral procedure on another claim and *Treatment Authorization Request* (TAR) line and add modifier 50 to the procedure code.

For bilateral procedures requiring a separate incision performed at the same operative session, providers should bill the first procedure on the first claim line with the appropriate CPT code followed by modifier AG, which indicates that the procedure is the primary surgery.

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 bilateral.

For example, to bill for bilateral inguinal hernia surgery in a child under 5 years of age, the provider would enter CPT code 49500 and modifier AG on the first claim line (indicating service is the primary surgery), then enter CPT code 49500 and modifier 50 on the second claim line, indicating that a bilateral procedure was performed.

Multiple Surgical Procedures: Modifier -51

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 (with the exception of special circumstances when providers are instructed in “Billing Multiple Modifiers” on a following page to use modifier -99 to indicate the additional procedures). 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. Four surgical procedures are shown. When performed during the same operative session and billed with modifier-51, the reimbursement is determined as follows.

Procedure/Modifier	**Full-Fee Rate ‹‹(in dollars)›› **	**Reimbursement Formula**
41150/-AG	973.19	100% of full fee rate
38720/-51	707.37	50% of full fee rate
15120/-51	409.53	50% of full fee rate
31600/-51	201.04	50% of full fee rate

Refer to “Surgeries Reimbursed at 100 Percent Even When Performed as a Multiple Surgery” on a following page for codes exempted from this policy.

Multiple Bilateral Procedures: Modifiers -AG, -50,-51 and -99

Providers use modifiers -AG, -50, -51 and -99 when billing for multiple bilateral procedures. A billing example illustrating how to bill for multiple bilateral procedures performed by the same physician during the same operative session is located in the appropriate Part 2 *Surgery Billing Examples* section.

Strabismus Procedures: Modifier -51 with CPT Code 67335

Modifier -51 must be used with CPT code 67335 to specifically identify the adjustable suture technique in the surgical correction of strabismus regardless of the number of muscles revised. The CPT book also directs providers to use the conventional strabismus procedure codes 67311 and 67312 to indicate the number of muscles involved: 67311 (one muscle) or 67312 (two muscles).

When submitting a claim for the adjustable suture technique in performing strabismus surgery, bill the technique code (67335) with modifier -51, and the appropriate basic code (67311 or 67312) with modifier -AG. Code 67335 billed with modifier -51 is reimbursed at 3.5 surgical units.

The basic code with modifier -AG is reimbursed at the lower of the allowed or the billed amount. The technique procedure code with modifier -51 is allowed at 3.5 surgical units.

"By Report" Billing

The following strabismus CPT procedure codes are billed "By Report."

CPT Code	Description
67314	Strabismus surgery, recession or resection procedure (patient not previously operated on); one vertical muscle (excluding superior oblique)
67316	Strabismus surgery, recession or resection procedure (patient not previously operated on);two or more vertical muscles (excluding superior oblique)
67320	Transposition procedure (e.g., for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)
67331	Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)
67334	Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)

Note: Providers must attach an operative report to the claim as these claims will suspend for medical review.

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 form using the appropriate CPT code with modifier 66.

Exception: Anesthesiologists should submit a separate claim using the appropriate five-digit anesthesia procedure code (00100 thru 01999) and modifier.

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 number 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. Information about NCCI-associated modifiers is included in the *Correct Coding Initiative: National* section of this manual.

Third and Subsequent Procedures

Modifier 99 also is used to indicate third and subsequent identical procedures. Modifier 51 is appropriate to indicate a second procedure and third or subsequent different procedures. However, if modifier 51 is used more than once to bill the same procedure code, it will appear to be a duplication. To avoid this problem, for example when billing the same procedure for multiple fingers or toes, bill the procedure on the first claim line with modifier AG, on the second claim line with modifier 51, and on the third and/or subsequent claim lines with modifier 99 and an explanation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim (example: Modifier 99 = Modifier AG + Modifier 51).

Hammertoe Operations: CPT Code 28285

Use modifier 99 when billing third and/or subsequent hammertoe operations (CPT code 28285).

"Add-on" Codes

Primary surgeons should not bill add-on codes where the descriptor is "each additional" with modifier 99 when performed on the same day or at the same operative session as another surgery. The add-on procedures in the following list are exempt from the multiple surgery reimbursement reduction when billed with modifier 51.

Note: Multiple assistant surgeon procedures must be billed with modifier 80 for the first procedure and modifier 99 for each additional procedure.

Surgeries Reimbursed at 100 Percent Even When Performed as a Multiple Surgery

When performed in addition to another surgery, the procedures billed with the following codes may be billed by the primary surgeon with modifier 51. These procedures are exempt from the multiple procedure reduction rule outlined in "Multiple Surgical Procedures: Modifier 51" on a previous page.

Surgical Procedure Codes Exempt from Reimbursement Cutback

10036	13133	15152	15772	19082	20700
11045	13153	15156	15774	19084	20701
11046	15003	15157	15777	19086	20702
11047	15005	15201	15787	19126	20703
11201	15101	15221	16036	19282	20704
11720	15111	15241	17003	19284	20705
11721	15116	15261	17004	19286	20930
11732	15121	15272	17312	19288	20931
11922	15131	15274	17314	19294	
13102	15136	15276	17315	19340	
13122	15151	15278	19001	20697	

Surgical Procedure Codes Exempt from Reimbursement Cutback (continued)

20936	22842	32506	33924	36474	37253
20937	22843	32507	34709	36483	38102
20938	22844	32667	34711	36555	38746
20939	22845	32668	34713	36556	38747
20974	22846	32674	34714	36568	38900
20975	22847	33141	34715	36569	43283
20979	22848	33225	34716	36580	43338
20985	22853	33257	34717	36584	43635
21088	22854	33258	34808	36620	44015
21089	22858	33259	34813	36625	44121
22103	22859	33367	35306	36823	44128
22116	22868	33368	35390	36907	44139
22208	22870	33369	35400	36908	44203
22216	26125	33419	35500	36909	44213
22226	26861	33508	35572	37195	44500
22328	26863	33517	35600	37222	44701
22512	27358	33518	35681	37223	44955
22515	27692	33519	35682	37232	47001
22534	29826	33521	35683	37233	47542
22552	31500	33522	35685	37234	47543
22585	31632	33523	35686	37235	47544
22614	31633	33530	35700	37237	47550
22632	31649	33572	36218	37239	48400
22634	31651	‹‹33746››	36227	37247	49326
22840	31654	33768	36228	37249	49327
22841	32501	33884	36248	37252	49412

Surgical Procedure Codes Exempt from Reimbursement Cutback (continued)

49435	58110	61799	64462	66990	95885
50606	58300	61800	64484	67225	95886
50705	58346	62148	64550	67320	95887
50706	58611	62160	64634	67331	96361
51725	59050	62252	64636	67332	96366
51726	59051	62367	64643	67334	96367
51727	59525	62368	64645	67335	96368
51728	60512	63035	64727	67340	96370
51729	61055	63043	64778	69300	96371
51736	61107	63048	64783	69990	96375
51741	61316	63057	64787	81266	96411
51784	61517	63066	64832	92618	96415
51785	61611	63076	64837	92621	96417
51792	61641	63078	64859	92627	99151
51797	61642	63082	64872	93352	99152
52442	61651	63086	64874	93662	99153
54240	61781	63091	64901	94729	99157
54250	61782	63103	64902	94781	99467
56606	61783	63308	64913	95873	
57465	61797	63621	65757	95874	

Assistant Surgeons: Modifiers 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. (Refer to the *Surgery Billing Examples* section in this manual for an illustrated sample.)

Note: Surgeries performed in an inpatient setting must be billed by the surgeon on a *CMS-1500* claim.

Assistant at Surgery: Podiatrists

Podiatrists may be reimbursed as an "assistant at surgery" when surgical procedure codes are billed with modifier 80. These services must be performed under the direct supervision of a licensed physician and surgeon (MD or DO).

Physician Assistant: Modifiers 99 = U7 + 80

Modifiers 99 = U7 + 80 are used to bill for a Physician Assistant (PA) who serves as first assistant in surgery under an approved supervising physician. The PA's services must be billed by the supervising physician and the appropriate surgical procedure code. For billing and reimbursement information for non-physician medical providers, see "Billing and Reimbursement" in the *Non-Physician Medical Practitioners (NMP)* section of this manual.

Gender Override

‹‹Instructions for overriding gender differences for procedures are in the *Transgender and Gender Diverse Services* section in the appropriate Part 2 provider manual.››

Override Medical Justification With Modifier 24, 25 or 57

For information regarding the use of modifier 24, 25 or 57 to override the medical justification requirement, see "Overriding Justification" in the *Evaluation and Management (E&M)* section of this manual.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.