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.

Modifier Placement on Claim Form

Modifier placement location appear as **"XX."** See claim form examples below:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To 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		Procedure Code	XX					NPI	
														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

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 <u>not</u> 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 = MODIFER 80 + 50.
LINE 3: EXCISION OF LESION MODIFER 99 = MODIFIERS 80 + 51.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To 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		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	

66 DX D1D1D1D D2D2D2D 68
0

69 ADMIT DX 70 PATIENT REASON DX 71 PPS CODE 72 ECI 73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE 75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

80 REMARKS
LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUINIONECTOMY, LT FOOT MODIFER 99 = MODIFERS 80 + 50. LINE 3: EXCISION OF LESION MODIFIER 99 = MODIFERS 80 + 51

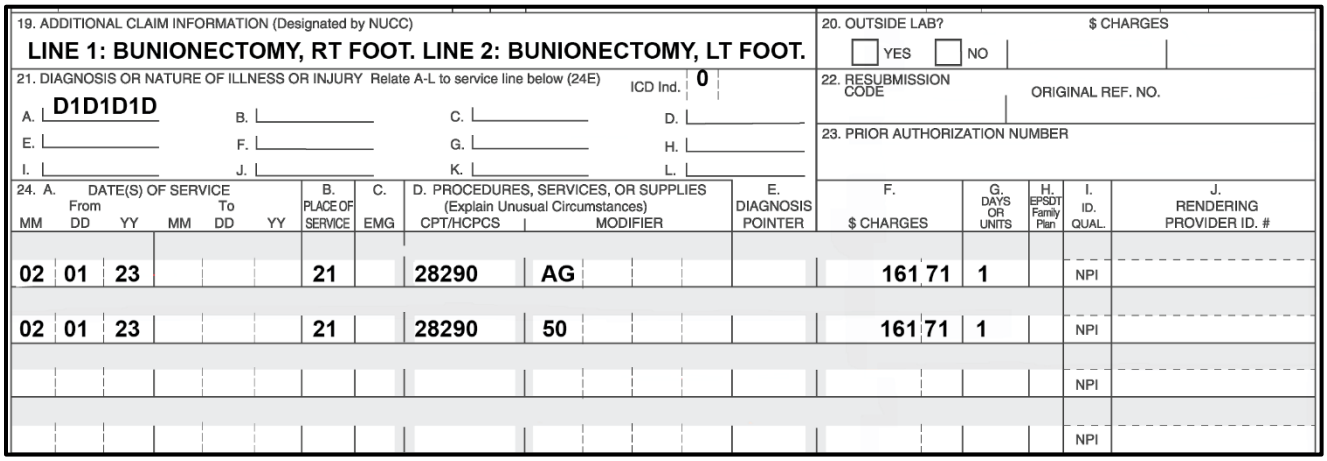
61 CC a. b. c. d.

76 ATTENDING NPI **1234567890** QUAL LAST FIRST
77 OPERATING NPI **2345678901** QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

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

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? ☐ YES ☐ NO $ CHARGES

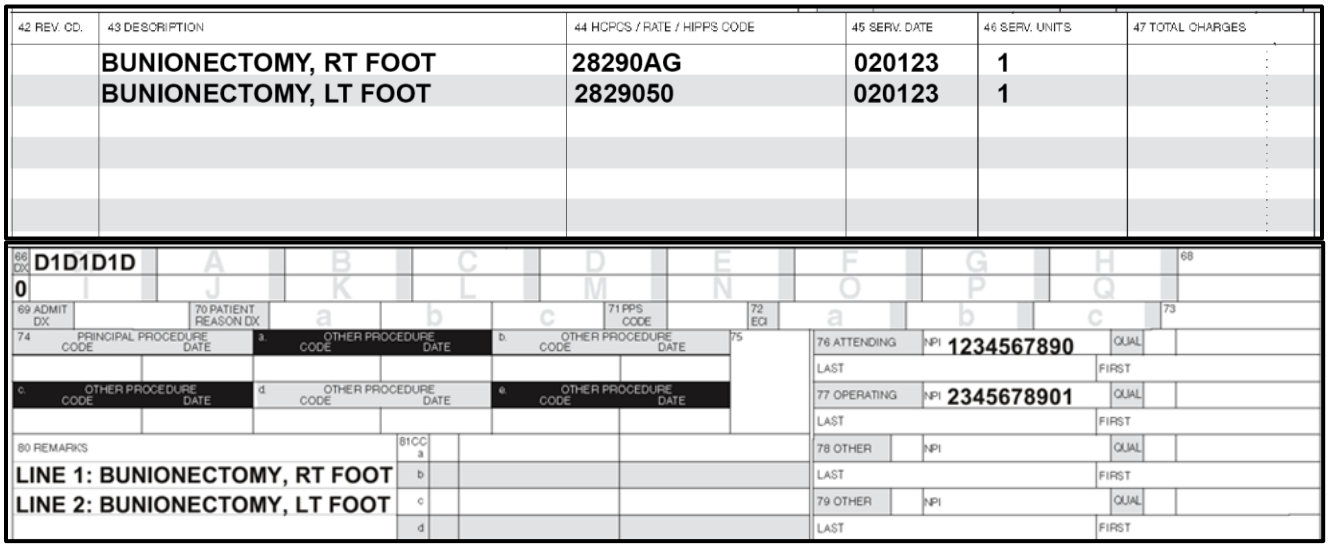
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. D1D1D1D B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To 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	

66 DX D1D1D1D
0
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI 1234567890 QUAL LAST FIRST
77 OPERATING NPI 2345678901 QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
LINE 1: BUNIONECTOMY, RT FOOT
LINE 2: BUNIONECTOMY, LT FOOT
81CC a b c d
68
73

Sample: Partial *UB-04* Bilateral Modifier 50

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? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

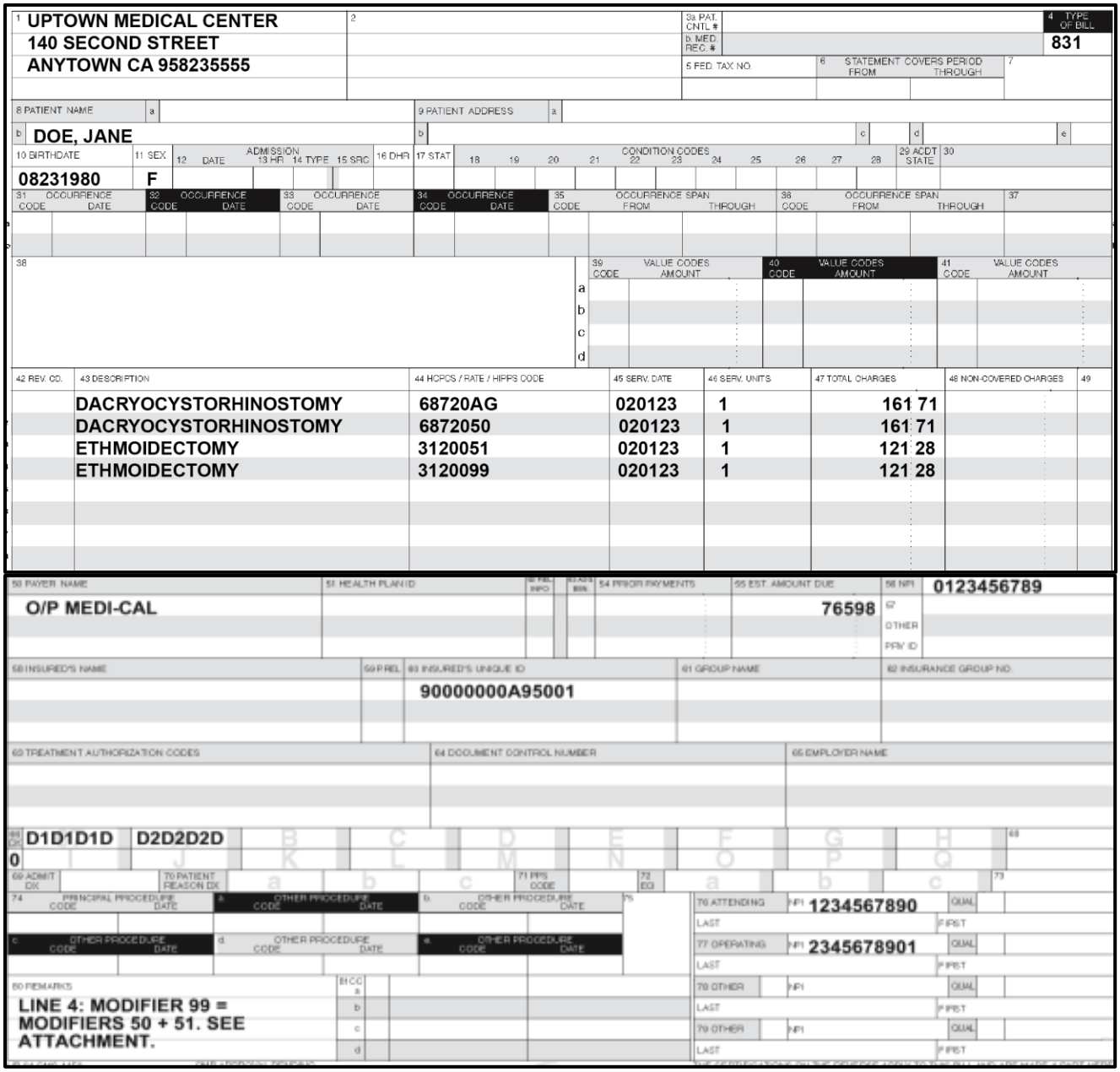
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To 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		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

4 TYPE OF BILL: 831

8 PATIENT NAME: DOE, JANE
10 BIRTHDATE: 08231980
11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	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
55 EST. AMOUNT DUE: 76598
56 NPI: 0123456789
60 INSURED'S UNIQUE ID: 90000000A95001
66 DX: D1D1D1D D2D2D2D
76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901
80 REMARKS: LINE 4: MODIFIER 99 = MODIFIERS 50 + 51. SEE ATTACHMENT.

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.

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 From MM	DD	YY	To 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		15002	AG		425 00	1		NPI	
02	01	23				21		15003	51		200 00	1		NPI	
02	01	23				21		15003	51		200 00	1		NPI	
02	01	23				21		15003	51		200 00	1		NPI	

24. A. DATE(S) OF SERVICE From MM	DD	YY	To 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		15002	AG		425 00	1		NPI	
02	01	23				21		15003	51		600 00	3		NPI	

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

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 prior 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) after 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.

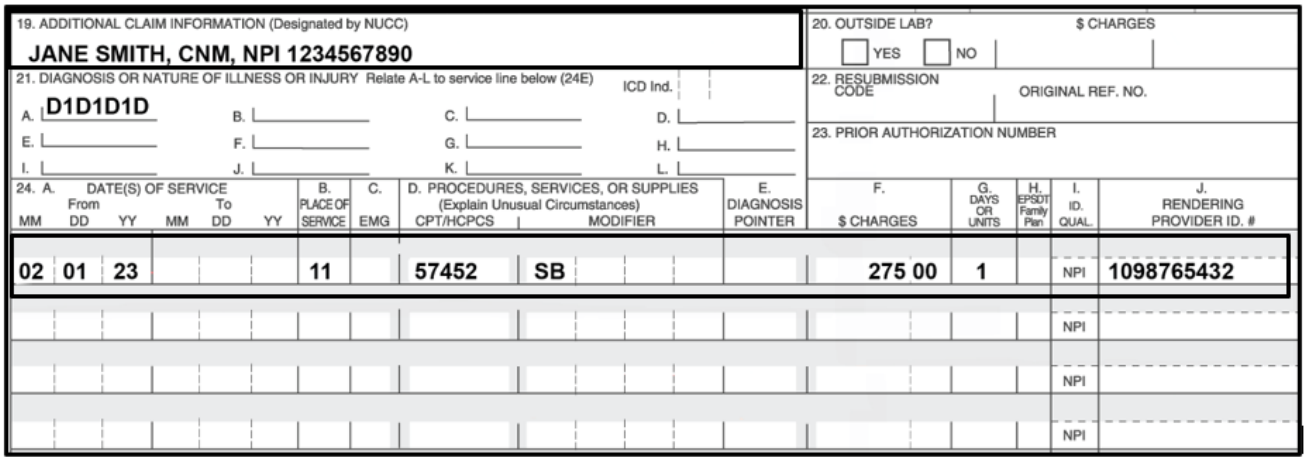
Note: Exceptions to this policy would be for a Certified Nurse Practitioner (CNP) or Certified Nurse Midwife (CNM) enrolled as an independent Medi-Cal provider or a Licensed Midwife.

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.

Non-Physician Medical Practitioner Claim Examples



19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
JANE SMITH, CNM, NPI 1234567890

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

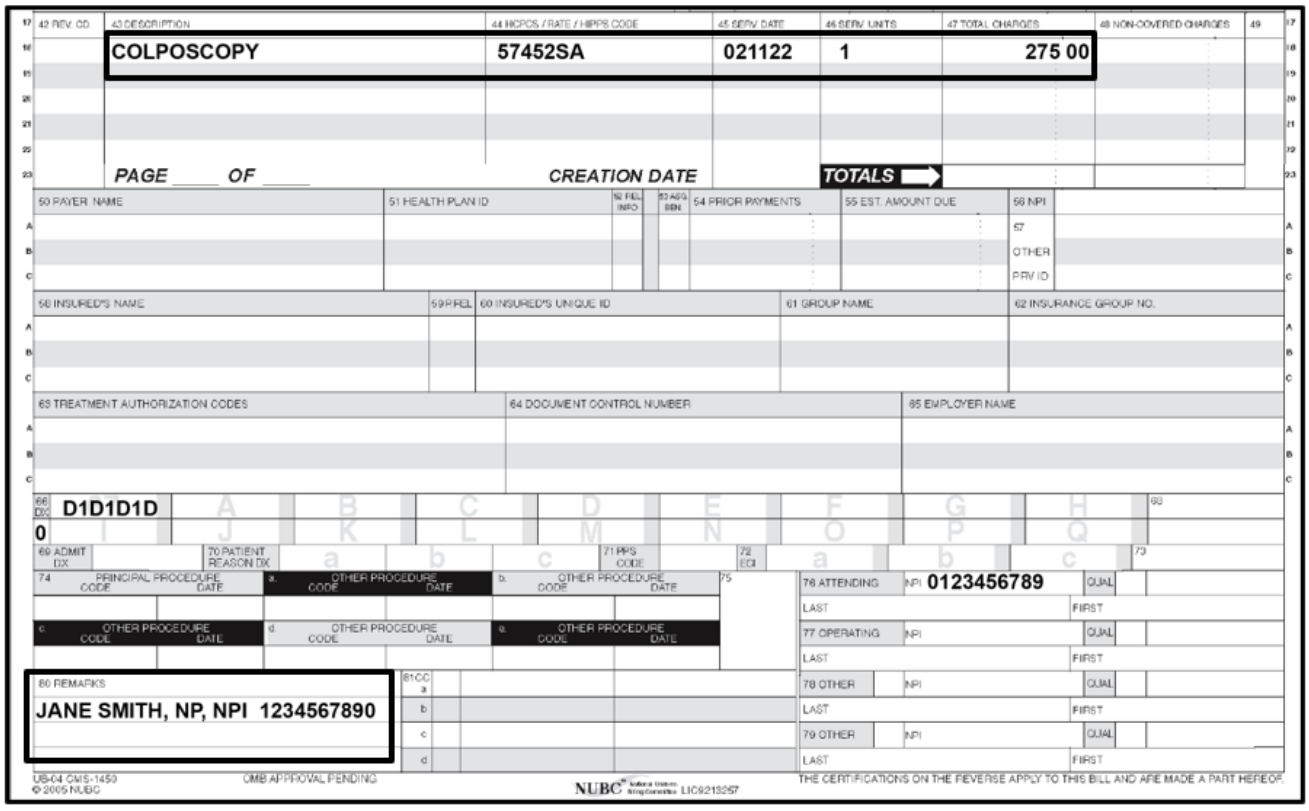
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. D1D1D1D B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To 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				11		57452	SB		275 00	1		NPI	1098765432
														NPI	
														NPI	
														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	48 NON-COVERED CHARGES
	COLPOSCOPY	57452SA	021122	1	275 00	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P REL | 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
0

67 A B C D E F G H I J K L M N O P Q

68 ADMIT DX | 69 PATIENT REASON DX | a b c | 70 PPS CODE | 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

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 0123456789 QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS
JANE SMITH, NP, NPI 1234567890

81 CC a b c d

UB-04 CMS-1450 © 2005 NUBC | OMB APPROVAL PENDING | NUBC | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: Partial *UB-04* Claim Form

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?

   a. Yes
   b. 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**