

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Surgery Billing Examples: CMS-1500

Examples in this section are to assist providers in billing for surgical procedures on the *CMS-1500* claim form. Refer to the surgery sections of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Modifier 50

Figure 1. Using Modifier 50 to Identify a Bilateral Procedure That Requires Additional Significant Time.

Modifier 50 is billed to identify a bilateral procedure that is more complex and/or requires additional significant time at a single operative session.

In this example, CPT-4 code 40701 (plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure) is the primary procedure and CPT-4 code 69436 (tympanostomy [requiring insertion of ventilating tube], general anesthesia) is the secondary procedure. Both procedures are bilateral.

Line 1: Enter code "40701" with modifier AG (primary surgeon) in the *Procedures, Services or Supplies* field (Box 24D). (This code does not require a 50 modifier because this is the primary surgery and the CPT-4 descriptor designates this is a bilateral procedure.)

Line 2: Enter code "69436" with modifier 51 (multiple procedures) in the *Procedures, Services or Supplies* field (Box 24D) to signify this is the secondary procedure.

Line 3: Enter code "69436" a second time with modifier 50 (bilateral procedure) in the *Procedures, Services or Supplies* field (Box 24D) to signify the procedure requires additional significant time at a single operative session.

In this example, ICD-9-CM code 749.24 (bilateral, incomplete cleft palate with cleft lip) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21, Number 1). This is the primary diagnosis. ICD-9-CM code 744.3 (unspecified anomaly of the ear) is entered as the secondary diagnosis code to support the need for the tympanostomy.

Enter the June 21, 2007 date of service as "062107" in the *Date(s) of Service* field (Box 24A). Enter Place of Service code "22" (outpatient hospital) in Box 24B.

In this example information explaining the bilateral procedures billed on claim lines 2 and 3 is entered in the *Reserved for Local Use* field (Box 19). This information is optional but is recommended because it helps claim examiners identify the location of bilateral procedures and process the claim more quickly.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a "1" in the *Days or Units* field (Box 24G) for code 40701 and each entry of code 69436.

Modifier AG

Figure 2. Enter the Primary, Bilateral and Multiple Procedure Modifiers AG, 50 and 51 in Box 24D.

In this example, CPT-4 code 28290 (hallux valgus [bunion] correction, with or without sesamoidectomy; simple exostectomy [Silver type procedure]) is the primary procedure.

Line 1: Enter code “28290” with modifier AG (primary surgeon) in the *Procedures, Services or Supplies* field (Box 24D).

Line 2: Enter code “28290” with modifier 50 (bilateral procedure) in the *Procedures, Services or Supplies* field (Box 24D) to signify the procedure requires additional significant time.

Line 3: Enter code “28080” with modifier 51 (multiple procedures) in the *Procedures, Services or Supplies* field (Box 24D) to signify this is the secondary procedure.

Enter the June 15, 2007 date of service as “061507” in the *Date(s) of Service* field (Box 24A). Enter Place of Service code “21” (inpatient hospital) in Box 24B.

In this example, information explaining the procedures billed on claim lines 1 through 3 is entered in the *Reserved for Local Use* field (Box 19). This information is optional but is recommended because it helps claim examiners identify the location of bilateral procedures and process the claim more quickly.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a “1” in the *Days or Units* field (Box 24G) for codes 28290 and 28080.

19. RESERVED FOR LOCAL USE LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT. LINE 3: EXCISION OF MORTON'S NEUROMA										20. OUTSIDE LAB? \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										<input type="checkbox"/> YES <input type="checkbox"/> NO					
1. _____ 3. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
2. _____ 4. _____										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. #
1 06 15 07 21 28290 AG 16171 1 NPI										FOR SUPPLIER INFORMATION					
2 06 15 07 21 28290 50 16171 1 NPI															
3 06 15 07 21 28080 51 12128 1 NPI															
4															

Figure 2: Enter the Primary, Bilateral and Multiple Procedure Modifiers AG, 50 and 51 in Box 24D.

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

Figure 3. Using modifiers AG, 50, 51 and 99 to identify multiple bilateral procedures.

In this example, three bilateral procedures are performed on the patient's eyes and nose by the same physician during the same operative session.

Line 1: Enter code "68720" with modifier AG (primary surgeon) in the *Procedures, Services or Supplies* field (Box 24D). This is the primary procedure.

Line 2: Enter code "68720" with modifier 50 (bilateral procedure) in the *Procedures, Services or Supplies* field (Box 24D) to signify this is bilateral to the primary procedure.

Line 3: Enter code "31200" with modifier 51 (multiple procedures) in the *Procedures, Services or Supplies* field (Box 24D) to signify this is the secondary procedure.

Line 4: Enter code "31200" with modifier 99 (multiple modifiers) in the *Procedures, Services or Supplies* field (Box 24D) to signify this procedure is billed with multiple modifiers.

Line 5: Enter code "30130" with modifier 51 (multiple procedures) in the *Procedures, Services or Supplies* field (Box 24D) to signify this is the third procedure.

Line 6: Enter code "30130" with modifier 99 (multiple modifiers) in the *Procedures, Services or Supplies* field (Box 24D) to signify this procedure is billed with multiple modifiers.

Enter the June 15, 2007 date of service as "061507" in the *Date(s) of Service* field (Box 24A). Enter Place of Service code "21" (inpatient hospital) in Box 24B.

In the *Reserved for Local Use* field (Box 19) document "LINES 4 AND 6: MODIFIER 99 = MODIFIERS 50 + 51."

In addition, "SEE ATTACHMENT" is entered in the *Reserved for Local Use* field (Box 19). The attachment is included with the claim because there is not enough room in the *Reserved for Local Use* field (Box 19) to explain the procedures billed on claim lines 1 through 6. This information is optional but is recommended because it helps claim examiners identify the location of bilateral procedures and process the claim more quickly.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a "1" in the *Days or Units* field (Box 24G) for all the procedure codes.

19. RESERVED FOR LOCAL USE											20. OUTSIDE LAB? \$ CHARGES						
LINES 4 AND 6: MODIFIERS 50 + 51. SEE ATTACHMENT.											<input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
1. _____ 3. _____											23. PRIOR AUTHORIZATION NUMBER						
2. _____ 4. _____																	
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 OF UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
1	06	15	07			21		68720	AG			16171	1		NPI		
2	06	15	07			21		68720	50			16171	1		NPI		
3	06	15	07			21		31200	51			12128	1		NPI		
4	06	15	07			21		31200	99			12128	1		NPI		
5	06	15	07			21		30130	51			10000	1		NPI		
6	06	15	07			21		30130	99			10000	1		NPI		

Figure 3: Using Modifiers AG, 50, 51 and 99 to Identify Multiple Bilateral Procedures.

Modifiers 80 and 99

Figure 4. Modifiers 80 and 99.

In this example, CPT-4 code 28290 (hallux valgus [bunion] correction, with or without sesamoidectomy; simple exostectomy [Silver type procedure]) is the primary procedure.

Line 1: Enter code “28290” with modifier 80 (indicating that an assistant surgeon rendered the service) in the *Procedures, Services or Supplies* field (Box 24D).

Line 2: Enter code “28290” with modifier 99 (signifying that the procedure is billed with a multiple modifier) in the *Procedures, Services or Supplies* field (Box 24D).

Line 3: Enter code “28080” with modifier 99 (signifying that the procedure is billed with a multiple modifier) in the *Procedures, Services or Supplies* field (Box 24D).

Enter the June 15, 2007 date of service as “061507” in the *Date(s) of Service* field (Box 24A). Enter Place of Service code “21” (inpatient hospital) in Box 24B.

In the *Reserved for Local Use* field (Box 19) enter “MODIFIER 99 = MODIFIER 80 + 50” for claim line 2 and “MODIFIER 99 = MODIFIER - 80 + 51” for claim line 3. This information is required. Information detailing the bilateral procedures also is included. This information is optional but is recommended because it helps claim examiners identify the location of bilateral procedures and process the claim more quickly.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for codes 28290 and 28080.

19. RESERVED FOR LOCAL USE LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT MODIFIER 99 = 80 + 50. LINE 3: EXCISION OF MORTON'S NEUROMA. MODIFIER 99 = 80 + 51.										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
24. A. DATE(S) OF SERVICE To B. PLACE OF C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS From To MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER										23. PRIOR AUTHORIZATION NUMBER						
										F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #		
1	06	15	07			21		28290	80			3271	1		NPI	
2	06	15	07			21		28290	99			3271	1		NPI	
3	06	15	07			21		28080	99			3228	1		NPI	
4															NPI	

FOR SUPPLIER INFORMATION

Figure 4: Modifiers 80 and 99.

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Destruction of Five Skin Lesions

Figure 5. Destruction of Five Skin Lesions With Modifiers AG and 51.

Bill code 17000 (destruction of first lesion) with modifier AG (primary surgeon) and code 17003 (destruction of second through 14 lesions) with modifier 51 (multiple procedures) in the *Procedures, Services or Supplies* field (Box 24D).

Enter the June 22, 2007 date of service as “062207” in the *Date(s) of Service* field (Box 24A). Enter Place of Service code “21” (inpatient hospital) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). In the *Days or Units* field (Box 24G) enter the number of lesions removed, as appropriate. For claim line 1 enter a 1 for code 17000 (first lesions). For claim line 2 enter a 4 for code 17003 (second through 14th lesions).

19. RESERVED FOR LOCAL USE LINE 1: DESTRUCTION/FIRST SKIN LESION. LINE 2: DESTRUCTION/MULTIPLE SKIN LESIONS 17003.										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.							
23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE										F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To																			
MM DD YY MM DD YY																			
B. PLACE OF SERVICE																			
C. EMG																			
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)																			
MODIFIER																			
E. DIAGNOSIS POINTER																			
1										2021		1		NPI					
2										4044		4		NPI					
3														NPI					
4														NPI					

Figure 5. Destruction of Five Skin Lesions With Modifiers AG and 51.

Destruction of 15 or More Skin Lesions

Figure 6. Destruction of 15 or More Skin Lesions With Modifier AG.

Bill code 17004 (destruction of 15 or more lesions) with modifier AG (primary surgeon) in the *Procedures, Services or Supplies* field (Box 24D).

Enter the May 11, 2007 date of service as “051107” in the *Date(s) of Service* field (Box 24A). Enter Place of Service code “21” (inpatient hospital) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a “1” in the *Days or Units* box of the claim. Specify the number of lesions removed in the *Reserved for Local Use* field (Box 19) of the claim (in this case 20 lesions were removed).

19. RESERVED FOR LOCAL USE 20 SKIN LESIONS REMOVED										20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										<input type="checkbox"/> YES <input type="checkbox"/> NO	
1. _____ 3. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
2. _____ 4. _____										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. #										FOR SUPPLIER INFORMATION	
1	06	11	07	21	17004	AG	19209	1	NPI	-----	
2									NPI	-----	
3									NPI	-----	
4									NPI	-----	

Figure 6. Destruction of 15 or More Skin Lesions With Modifier AG.