

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

surg bill ub

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Surgery Billing Examples: UB-04

Examples in this section are to help providers bill surgical procedures on the *UB-04* claim form. Refer to the *Surgery* sections of this manual for detailed policy information. Refer to the *UB-04 Completion: Outpatient Services* 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 *Remarks* field (Box 80) 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. This is a sample only. Please adapt to your billing situation.

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 code 69436 (tympanostomy [requiring insertion of ventilating tube], general anesthesia) is the secondary procedure. Both procedures are bilateral. This example is for services rendered in an outpatient hospital setting.

Enter the two-digit facility type code "13" (hospital – outpatient) and one-character claim frequency code "1" as "131" in the *Type of Bill* field (Box 4).

Line 1: Enter code 40701 with modifier AG (primary surgeon) in the *HCPCS/Rate* field (Box 44). (This code does not require modifier 50 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 *HCPCS/Rate* field (Box 44) to signify this is the secondary procedure.

Line 3: Bill code 69436 a second time with modifier 50 (bilateral procedure) in the *HCPCS/Rate* field (Box 44) to signify the procedure requires additional significant time at a single operative session.

Enter the date of service, June 21, 2007, for each entry in six-digit format as 062107 in the *Service Date* field (Box 45). Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The outpatient hospital's NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-9-CM diagnosis code is entered in Box 67. In this example, ICD-9-CM code 749.24 represents a bilateral, incomplete cleft palate with cleft lip and is entered as 74924. This is the primary diagnosis. ICD-9-CM code 744.3 (unspecified anomaly of the ear) is entered as the secondary diagnosis code (as 7443) to support the need for the tympanostomy.

The referring physician's NPI number is entered in the *Attending* field (Box 76). The rendering physician's NPI number is placed in the *Operating* field (Box 77).

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1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT CNTL # b MED REC #		4 TYPE OF BILL 131	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
8 PATIENT NAME DOE JANE		9 PATIENT ADDRESS					
10 BIRTHDATE 08242002		11 SEX F		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 CODE		36 OCCURRENCE SPAN FROM		37 THROUGH	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1		REPAIR OF DEFORMITY		40701AG		062107	
2		TYMPANOSTOMY		6943651		062107	
3		ADDITIONAL TIME		6943650		062107	
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23		001 PAGE OF		CREATION DATE		TOTALS → 541000	
50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID		52 REL INFO		53 ASG BGN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 541000		56 NPI 0123456789		57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES 01234567890		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 74924		67 DX 7443		68		69	
70 PATIENT REASON DX		71 PPS CODE		72 EQ		73	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI 1234567890		77 QUAL	
78 LAST		79 FIRST		80 QUAL		81	
77 OPERATING NPI 2345678901		78 QUAL		79 LAST		80 FIRST	
81 OTHER NPI		82 QUAL		83 LAST		84 FIRST	
85 OTHER NPI		86 QUAL		87 LAST		88 FIRST	
80 REMARKS		81 CC a		82 b		83 c	
		84 d		85		86	

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

Modifier AG

Figure 2. Using modifier AG to identify the primary surgeon.

Modifier AG is billed to indicate the primary surgeon performed the procedure. In this example, CPT-4 code 28290 (hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy [Silver type procedure]) is the primary procedure. This example is for services rendered in an ambulatory surgery center.

Enter the two-digit facility type code "83" (special facility – ambulatory surgery center) and one-character claim frequency code "1" as "831" in the *Type of Bill* field (Box 4).

Line 1: Enter code 28290 with modifier AG (primary surgeon) in the *HCPCS/Rate* field (Box 44).

Line 2: Enter code 28290 with modifier 50 (bilateral procedure) in the *HCPCS/Rate* field (Box 44) to signify the procedure requires additional significant time.

Line 3: Enter code 28080 with modifier 51 (multiple procedures) in the *HCPCS/Rate* field (Box 44) to signify this is the secondary procedure.

Enter the date of service, June 14, 2007, for each entry in six-digit format as 061407 in the *Service Date* field (Box 45). Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The surgery clinic's NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-9-CM diagnosis code is entered in Box 67. In this example, ICD-9-CM code 727.1 represents a bunion and is entered as 7271. This is the primary diagnosis. ICD-9-CM code 355.6 (lesion of plantar nerve) is entered as the secondary diagnosis code (as 3556) and represents a diagnosis of a Morton's neuroma.

Enter the referring provider's NPI number in the *Attending* field (Box 76). The rendering physician's NPI number is placed in the *Operating* field (Box 77).

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1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2	3a PAT CNTL #	3b MED REC #	4 TYPE OF BILL
			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH
8 PATIENT NAME		9 PATIENT ADDRESS			
b DOE JANE		c		d	
10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC
08241980	F				
16 DHR	17 STAT	18	19	20	21
CONDITION CODES					
22	23	24	25	26	27
28	29 ACCT STATE	30			
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN FROM
					THROUGH
					THROUGH
					THROUGH
38	39 VALUE CODES CODE		40 VALUE CODES CODE		41 VALUE CODES CODE
	AMOUNT		AMOUNT		AMOUNT
a					
b					
c					
d					
42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	BUNIONECTOMY, RT FOOT	28290AG	061407	1	16171
2	BUNIONECTOMY, LF FOOT	2829050	061407	1	16171
3	EXCISION MORTON'S NEUROMA	2808051	061407	1	12128
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23	001	PAGE	OF	CREATION DATE	TOTALS → 44470
50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
O/P MEDI-CAL					44470
56 NPI	57 OTHER				0123456789
	58 INSURED'S NAME				59 PREL
	90000000A95001				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	7271	3556	B	C	D
	E	F	G	H	I
	J	K	L	M	N
	O	P	Q	R	S
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73	
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI
		1234567890	2345678901		
		QUAL	QUAL	QUAL	QUAL
		LAST	LAST	LAST	LAST
		FIRST	FIRST	FIRST	FIRST
80 REMARKS	81 CC a				
	b				
	c				
	d				

Figure 2: Enter the Primary, Bilateral and Multiple Procedure Modifiers AG, 50, 51 in Box 44.

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.

Enter the two-digit facility type code "83" (special facility – ambulatory surgery center) and one-character claim frequency code "1" as "831" in the *Type of Bill* field (Box 4).

Line 1: Enter code "68720" with modifier AG (primary surgeon) in the *HCPCS/Rate* field (Box 44). This is the primary procedure.

Line 2: Enter code "68720" with modifier 50 (bilateral procedure) in the *HCPCS/Rate* field (Box 44) to signify this is bilateral to the primary procedure.

Line 3: Enter code "31200" with modifier 51 (multiple procedures) in the *HCPCS/Rates* field (Box 44) to signify this is the secondary procedure.

Line 4: Enter code "31200" with modifier 99 (multiple modifiers) in the *HCPCS/Rate* field (Box 44) to signify this procedure is billed with multiple modifiers.

Line 5: Enter code "30130" with modifier 51 (multiple procedures) in the *HCPCS/Rate* field (Box 44) to signify this is the third procedure.

Line 6: Enter code "30130" with modifier 99 (multiple modifiers) in the *HCPCS/Rate* field (Box 44) to signify this procedure is billed with multiple modifiers.

Enter the date of service, June 15, 2007, for each entry in six-digit format as 061507 in the *Service Date* field (Box 45). Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The surgery clinic's NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-9-CM diagnosis code is entered in Box 67. In this example, ICD-9-CM code 375.56 (stenosis of nasolacrimal duct, acquired) is entered as 37556. This is the primary diagnosis. The secondary diagnosis code, ICD-9-CM code 375.22 (epiphora due to insufficient drainage), is entered as 37522.

Enter the referring provider's NPI number in the *Attending* field (Box 76). The rendering physician's NPI number is placed in the *Operating* field (Box 77).

In the *Remarks* field (Box 80) document "LINES 4 AND 6: MODIFIER 99 = MODIFIERS 50 + 51. This information is required.

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

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL 831	
8 PATIENT NAME a DOE JANE				9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1		DACRYOCYSTORHINOSTOMY		68720AG		061507 1 16171	
2		DACRYOCYSTORHINOSTOMY		6872050		061507 1 16171	
3		ETHMOIDECTOMY		3120051		061507 1 12128	
4		ETHMOIDECTOMY		3120099		061507 1 12128	
5		EXCISION TURBINATE		3013051		061507 1 10000	
6		EXCISION TURBINATE		3013099		061507 1 10000	
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23		001 PAGE OF		CREATION DATE		TOTALS 76598	
50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID		52 REL. INFO		53 ASQ BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 76598		56 NPI 0123456789		57 OTHER PRV ID	
58 INSURED'S NAME		59 P.FEL		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62 INSURANCE GROUP NO		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 37556 37522		67		68		69	
70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE DATE		75 OTHER PROCEDURE DATE		76 ATTENDING NPI 1234567890		QUAL	
77 OPERATING NPI 2345678901		78 OTHER NPI		79 OTHER NPI		QUAL	
80 REMARKS LINES 4 AND 6: MODIFIER 99=50+51. SEE ATTACHMENT.		81CC a		81CC b		81CC c	
81CC d		81CC e		81CC f		81CC g	

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

Modifiers 80 and 99

Figure 4. Using modifier 80 to identify the assistant surgeon and modifier 99 to identify multiple modifiers. This example is for services rendered in an ambulatory surgical center.

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

Enter the two-digit facility type code “83” (special facility – ambulatory surgical center) and one-character claim frequency code “1” as “831” in the *Type of Bill* field (Box 4).

Line 1: Enter code 28290 with modifier 80 (signifying that an assistant surgeon rendered the service) in the *HCPCS/Rate* field (Box 44).

Line 2: Enter code 28290 with modifier 99 (signifying that the procedure is billed with multiple modifiers) in the *HCPCS/Rate* field (Box 44).

Line 3: Enter code 28080 (excision, interdigital (Morton) neuroma, single, each) with modifier 99 (signifying that the procedure is billed with multiple modifiers) in the *HCPCS/Rate* field (Box 44).

Enter the date of service, June 23, 2007, for each entry in six-digit format as 062307 in the *Service Date* field (Box 45). Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The surgery clinic’s NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-9-CM diagnosis code is entered in Box 67. In this example, ICD-9-CM code 727.1 represents a bunion and is entered as 7271. This is the primary diagnosis. ICD-9-CM code 355.6 (lesion of plantar nerve) is entered as the secondary diagnosis code (as 3556) and represents diagnosis of a Morton’s neuroma.

In the *Remarks* field (Box 80) enter wording that explains modifier 99 equals billing of both modifiers 80 (assistant surgeon) and 50 (bilateral procedure) for claim line 1, and 80 and 51 (multiple procedures) for claim line 3. This information is required.

Enter the NPI number of the referring provider in the *Attending* field (Box 76). The rendering physician NPI number is placed in the *Operating* field (Box 77).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT CNTL # b MED REC #		4 TYPE OF BILL 831	
8 PATIENT NAME a				9 PATIENT ADDRESS a			
b DOE JANE							
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1		BUNIONECTOMY, RT FOOT		2829080		062307	
2		BUNIONECTOMY, LF FOOT		2829099		062307	
3		EXCISION MORTON'S NEUROMA		2808099		062307	
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50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID		52 REL INFO		53 ASG SER	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 9770		56 NPI 0123456789		57 OTHER PRV ID	
58 INSURED'S NAME		59 P.PEL		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 EX 7271		67 3556		68		69	
70 PATIENT REASON DX		71 FPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI 1234567890		77 QUAL	
78 LAST		79 FIRST		80 LAST		81 FIRST	
82 OTHER PROCEDURE CODE		83 OTHER PROCEDURE CODE		84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE CODE	
86 LAST		87 FIRST		88 LAST		89 FIRST	
90 REMARKS		91 CC		92		93	
94		95		96		97	
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106		107		108		109	
110		111		112		113	
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510		511		512		513	
514		515		516		517	
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666		667		668		669	
670		671		672		673	
674		675		676		677	
678		679		680		681	
682		683		684		685	
686		687		688		689	
690		691		692		693	
694		695		696		697	
698		699		700		701	
702		703		704		705	
706		707		708		709	
710		711		712		713	
714		715		716		717	
718		719		720		721	
722		723		724		725	
726		727		728		729	
730		731		732		733	
734		735		736		737	
738		739		740		741	
742		743		744		745	
746		747		748		749	
750		751		752		753	
754		755		756		757	
758		759		760		761	
762		763		764		765	
766		767		768		769	
770		771		772		773	
774		775		776		777	
778		779		780		781	
782		783		784		785	
786		787		788		789	
790		791		792		793	
794		795		796		797	
798		799		800		801	

**Destruction of Five
Skin Lesions**

*Figure 5. Destruction of five skin lesions – modifiers AG and 51.
This example is for services rendered in an outpatient hospital clinic.*

Bill CPT-4 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 *HCPCS/Rates* field (Box 44).

Enter the two-digit facility type code “13” (hospital – outpatient) and one-character claim frequency code “1” as “131” in the *Type of Bill* field (Box 4).

The date of service, June 17, 2007, is entered for each entry in six-digit format as 061707 in the *Service Date* field (Box 45). Enter a 1 in the *Service Units* field (Box 46) for code 17000 to indicate that one lesion was removed. Enter a 4 in the *Service Units* field (Box 46) for code 17003 to indicate that, in addition to the first lesion, four more lesions were removed. Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The county hospital’s NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-9-CM diagnosis code is entered in Box 67. In this example, ICD-9-CM code 709.9 represents dermal (skin) lesions and is entered as 7099.

The rendering physician provider number is placed in the *Operating* field (Box 77).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT. CNTRL. # b. MED. REC. #		4 TYPE OF BILL 131	
8 PATIENT NAME a. DOE JANE				9 PATIENT ADDRESS a.			
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1		DESTRUCTION/FIRST SKIN LESION		17000AG		061707	
2		DESTRUCTION/MULT. SKIN LESION		1700351		061707	
3							
4							
5							
6							
7							
8							
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12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		001 PAGE OF		CREATION DATE		TOTALS 6065	
50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 6065		56 NPI 0123456789		57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 7099		70 PATIENT REASON DX		71 FPS CODE		72 EQ	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 OPERATING NPI	
78 OTHER NPI		79 OTHER NPI		QUAL		FIRST	
80 REMARKS		b1CC a		b		c	
		b		c		d	
		c		d		e	
		d		e		f	

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

**Destruction of 15 or
More Skin Lesions**

*Figure 6. Destruction of 15 or more skin lesions – modifier AG.
This example is for services rendered in an outpatient hospital clinic.*

Bill code 17004 (destruction of 15 or more lesions) with modifier AG (primary surgeon) in the *HCPCS/Rates* field (Box 44).

Enter the two-digit facility type code “13” (hospital – outpatient) and one-character claim frequency code “1” as “131” in the *Type of Bill* field (Box 4).

Enter the date of service, June 12, 2007, in six-digit format as 061207 in the *Service Date* field (Box 45). Enter a 1 in the *Service Units* field (Box 46) for code 17004 to indicate that 15 or more lesions were removed. Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23).

The county hospital’s NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-9-CM diagnosis code is entered in Box 67. In this example, ICD-9-CM code 709.9 represents dermal (skin) lesions and is entered as 7099.

The rendering physician provider number is placed in the *Operating* field (Box 77).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT CNTRL #		4 TYPE OF BILL 131	
b PATIENT NAME DOE JANE		9 PATIENT ADDRESS					
10 BIRTHDATE 08241980	11 SEX F	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE	
35 OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37			
39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT			
42 REV. CD.	43 DESCRIPTION	44 HCPCS /RATE / HIPPS CODE		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	DESTRUCTION/MULT. SKIN LESION	17004AG		061207	1	19209	
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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17							
18							
19							
20							
21							
22							
23	001	PAGE	OF	CREATION DATE	TOTALS	19209	
50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID		52 REL INFO	53 ASO BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 19209
58 INSURED'S NAME		59 P.PREL		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 7099		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 ATTENDING LAST FIRST		77 OPERATING LAST FIRST	
78 OTHER LAST FIRST		79 OTHER LAST FIRST		76 ATTENDING NPI		77 OPERATING NPI 1234567890	
80 REMARKS		81CC a		82 OTHER LAST FIRST		83 OTHER LAST FIRST	

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