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
- Identify modifiers used by a surgical team member
- Review pre-operative and post-operative services policy
- Identify modifiers for Non-Physician Medical Practitioners (NMPs)
- Discuss the discontinuation of local modifier ZS
- Provide general information regarding anesthesia-related drug and supply modifiers
- Explain “By Report” documentation

Resource Information

**Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at ([www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss)).
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)
Modifiers: Approved List (modif app)
Modifiers Used With Procedure Codes (modif used)
Non-Physician Medical Practitioners (NMP) (non ph)
Radiology (radi)
Radiology: Diagnostic (radi dia)
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)

Acronyms
A list of current acronyms is located in the Appendix section of this workbook.

NOTES
Description

The use of modifiers is an important 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>
<thead>
<tr>
<th>Anesthesia Drugs &amp; Supplies: UA, UB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management: 24, 25</td>
</tr>
<tr>
<td>General Use: 22, 26, 52, 54, 55, 62, 66, 78, 79, 99</td>
</tr>
<tr>
<td>Non-physician Medical Practitioner: U7, SA, SB</td>
</tr>
<tr>
<td>Radiology: 26, TC</td>
</tr>
</tbody>
</table>

Use of a modifier with a CPT-4 or HCPCS code does not ensure reimbursement. Documentation of medical necessity may also be required for certain procedure codes.

Surgical Modifier Policies

Refer to the *Modifiers: Approved List* section (modif app) in the Part 2 provider manual for a complete list of approved modifier codes for billing Medi-Cal. Modifiers not listed in the *Modifiers: Approved List* section are unacceptable for billing Medi-Cal.

Surgical Procedures Codes and Modifiers

**Inappropriate Modifier Use**

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.
Claim Form Placement

Modifier form locations appear as "XX." See claim form examples below:

Sample: Partial CMS-1500 Claim Form

Sample: Partial UB-04 Claim Form

Billing Modifiers for Surgical Procedures

Primary Surgeon Modifiers

Codes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AG</td>
<td>Primary Surgeon</td>
</tr>
<tr>
<td></td>
<td>Multiple Primary Surgeons</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedures</td>
</tr>
<tr>
<td>99</td>
<td>Multiple Modifiers</td>
</tr>
</tbody>
</table>

Modifier Description

Primary Surgeon (Modifier AG)

The primary surgeon or podiatrist is required to use modifier AG on the only, or the highest valued, procedure code being billed for the date of service.

NOTE

Modifier AG exception: CPT-4 code 58565 (hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) must not be billed with modifier AG. Claims submitted with code 58565 and modifier AG will be returned to the provider. See the Sterilization (ster) section in the appropriate Part 2 provider manual for details.
Multiple Primary Surgeons (Modifier AG)
Two or more surgeons may use modifier AG for the same patient on the same date of service, 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 Exceptions
The following medical policies have been established for specific, multiple surgeries and are not reimbursable 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-4 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-4 codes 58700, 58720, 58900 – 58943) billed on the same date of service as a hysterectomy (CPT-4 codes 58150 – 58285) is not separately reimbursable.
- A vaginal delivery (CPT-4 codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT-4 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 bladder catheter (CPT-4 codes 51701 and 51702) is not separately reimbursable when billed with CPT-4 codes 10021 – 69979.
- CPT-4 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-4 code within the ranges of 0100 – 69999 and 96360 – 96549.

National Correct Coding Initiative (NCCI)
A number of surgical procedures are subject to NCCI edits. To process correctly, claims submitted for multiple surgical procedures on the same day may require the addition of an NCCI-associated modifier. Information about NCCI-associated modifiers is included in the Surgery: Billing with Modifiers section of the Part 2 provider manual (surg bill mod, page 5).

Bilateral Procedures (Modifier 50)
Modifier 50 is used when bilateral procedures performed add significant time or complexity to patient care at a single operative session.

NOTE
Check CPT-4 code for procedure descriptor.
**Claim Form Examples Using Modifier 50**

**Sample: Partial CMS-1500 Claim Form**

<table>
<thead>
<tr>
<th>Line</th>
<th>Procedure Code</th>
<th>Diagnosis Code</th>
<th>Diagnoses</th>
<th>Place of Service</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>28290AG</td>
<td>101116</td>
<td>1</td>
<td>10/11/16</td>
<td>16171</td>
</tr>
<tr>
<td>2</td>
<td>2829050</td>
<td>101116</td>
<td>1</td>
<td>10/11/16</td>
<td>16171</td>
</tr>
</tbody>
</table>

**Sample: Partial UB-04 Claim Form**

<table>
<thead>
<tr>
<th>Line</th>
<th>Procedure Code</th>
<th>Diagnosis Code</th>
<th>Diagnosis</th>
<th>Place of Service</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1234567890</td>
<td></td>
<td>1</td>
<td>10/11/16</td>
<td>16171</td>
</tr>
<tr>
<td>2</td>
<td>2345678901</td>
<td></td>
<td>1</td>
<td>10/11/16</td>
<td>16171</td>
</tr>
</tbody>
</table>

**Sample: Partial UB-04 Claim Form: Remarks field (Box 80)**
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.

Sample: Partial CMS-1500 Claim Form

Sample: Partial UB-04 Claim Form

Multiple Procedures (Modifier 51)

The multiple procedures modifier identifies the secondary, additional or lesser procedures for multiple procedures that are performed on the same day or at the same operative session.
Surgical Modifiers

Reimbursement Rule:

<table>
<thead>
<tr>
<th>CPT-4 Code/Modifier</th>
<th>Reimbursement Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>41150 AG</td>
<td>100% of full-fee rate</td>
</tr>
<tr>
<td>38720 51</td>
<td>50% of full-fee rate</td>
</tr>
<tr>
<td>15120 51</td>
<td>50% of full-fee rate</td>
</tr>
<tr>
<td>31600 51</td>
<td>50% of full-fee rate</td>
</tr>
</tbody>
</table>

Billing Tip: 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.

Modifier 51 Versus Modifier 99
- Modifier 51 describes second, third or subsequent differing procedures.
- Modifier 99 describes third and subsequent identical procedures.

Assistant Surgeon Modifiers

Codes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
</tr>
<tr>
<td>99</td>
<td>Multiple Modifiers</td>
</tr>
</tbody>
</table>

Modifier Descriptions

Assistant Surgeon (Modifier 80)
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 any multiple surgical procedures must be identified by the use of modifier 99 (multiple modifiers).

NOTE
Not all surgical procedures reimburse for an assistant surgeon. To determine if there are any restrictions refer to the TAR and Non-Benefit: Introduction to List section (tar and non) in the appropriate Part 2 provider manual to verify.

Multiple Modifiers (Modifier 99)
Under certain circumstances two or more modifiers may be necessary to completely define a service.
- Use modifier 99 with the appropriate procedure code.
- Explain modifier 99 in the Remarks field (Box 80) for UB-04 claims and Additional Claim Information field (Box 19) for CMS-1500 claims.
### Surgical Modifiers

#### Partial CMS-1500 Claim Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Service Code</th>
<th>Procedure Code</th>
<th>Description</th>
<th>CHGS</th>
<th>CHG UNITS</th>
<th>CHGS UNITS</th>
<th>TOTAL CHARGES</th>
<th>ALLOWED CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/11/16</td>
<td>21</td>
<td>XXXXX</td>
<td>80</td>
<td>129000</td>
<td>6</td>
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<td></td>
<td></td>
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</tbody>
</table>

#### Partial UB-04 Claim Form

<table>
<thead>
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<th>Date</th>
<th>Service Code</th>
<th>Procedure Code</th>
<th>Description</th>
<th>CHGS</th>
<th>CHG UNITS</th>
<th>CHGS UNITS</th>
<th>TOTAL CHARGES</th>
<th>ALLOWED CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/11/16</td>
<td>21</td>
<td>XXXXX99</td>
<td>021116</td>
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</table>

### Partial UB-04 Claim Form

<table>
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<th>Procedure Code</th>
<th>Description</th>
<th>CHGS</th>
<th>CHG UNITS</th>
<th>CHGS UNITS</th>
<th>TOTAL CHARGES</th>
<th>ALLOWED CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
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<td>XXXXX99</td>
<td>021116</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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. If billing multiple codes that have "each additional" in the descriptor use 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.

**CMS-1500 Form**

### Current Billing Method

<table>
<thead>
<tr>
<th>A</th>
<th>DATES OF SERVICE</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
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<td>11 16</td>
<td>21</td>
<td>15002</td>
<td>AG</td>
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<td></td>
<td>42500</td>
<td>1</td>
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<td>11 16</td>
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<td>1</td>
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### Preferred Billing Method

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<th>C</th>
<th>D</th>
<th>E</th>
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<td>15002</td>
<td>AG</td>
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<td></td>
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<td>42500</td>
<td>1</td>
</tr>
<tr>
<td>02</td>
<td>11 16</td>
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### UB-04 Form

#### Current Billing Method

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<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>15002AG</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>20000</td>
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</tr>
<tr>
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<td>021116</td>
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<td>20000</td>
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</tr>
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</table>

#### Preferred Billing Method

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>15002AG</td>
<td>021116</td>
<td>1</td>
<td>42500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1500351</td>
<td>021116</td>
<td>3</td>
<td>60000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other Surgical Modifiers

If modifiers U7, 22, 62, 66, 78, 79 or 80 are used for multiple surgical procedures billed by someone other than the primary surgeon (AG), then use modifier 99 with the appropriate procedure code. Explain modifier 99 in the Remarks field (Box 80) on UB-04 claims and Additional Claim Information field (Box 19) on CMS-1500 claims.

NOTE
When billing for a primary surgeon with modifier AG, use modifier 51 for second, third or subsequent differing procedures. Use modifier 99 for third or subsequent identical procedures.

Complex Operative Procedure Modifiers

Codes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Services</td>
</tr>
</tbody>
</table>

Modifier Descriptions

**Increased Procedural Services (Modifier 22)**
Describes procedures involving significantly increased operative complexity and/or time in a significantly altered surgical field resulting from the effects of:

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

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.

NOTES

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Additional Surgeon(s) Modifiers

**Codes**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>Two Surgeons</td>
</tr>
<tr>
<td>66</td>
<td>Surgical Team</td>
</tr>
</tbody>
</table>

**Modifier Descriptions**

**Two Surgeons (Modifier 62)**
Identifies a surgical procedure that requires two surgeons who are performing distinct parts of a procedure.

**NOTE**
Each surgeon would bill with modifier 62.

**Surgical Team (Modifier 66)**
Indicates the services of all physician members of a surgical team. Anesthesiologists must submit a separate claim for services.

**NOTE**
CPT-4 guidelines for modifier 66 allow each member of a surgical team to bill separately for their services; however, Medi-Cal requires that all team members bill on the same claim form.
Operative/Postoperative Modifiers

Codes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Reduced services</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative Management only</td>
</tr>
<tr>
<td>58</td>
<td>NCCI-associated Staged or related procedure by the same physician during the postoperative period</td>
</tr>
</tbody>
</table>

Modifier Descriptions

**Reduced Services (Modifier 52)**

**Operative Postoperative Management (Modifier 54)**
Surgical care only

**Operative Postoperative Management (Modifier 55)**
Post-operative management only

**Staged or Related Procedure Postoperative Period (Modifier 58)**
May be used with CPT-4 codes 15002 – 15429 and 52601 to address subsequent part(s) of a staged procedure.
Additional Operative Procedure Modifiers

Codes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78</td>
<td>Unplanned return to operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated procedure or service by the same physician during the postoperative period</td>
</tr>
</tbody>
</table>

Modifier Descriptions

Return to Operating Room (Modifier 78)
Unplanned return to the operating/procedure room by the same physician following the initial procedure during the postoperative period.

Return to Operating Room (Modifier 79)
Unrelated procedure or service by the same physician during the postoperative period

Use of Discontinued Procedure Modifiers

Codes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Discontinued procedure; requires “By Report” documentation</td>
</tr>
<tr>
<td>73</td>
<td>Discontinued procedure in an outpatient hospital/ambulatory surgery center prior to the administration of anesthesia</td>
</tr>
<tr>
<td>74</td>
<td>Discontinued procedure in an outpatient hospital/ambulatory surgery center after administration of anesthesia</td>
</tr>
</tbody>
</table>

NOTE
A number of surgical procedures are subject to NCCI edits. To process correctly, claims submitted for multiple surgical procedures on the same day may require the addition of an NCCI-associated modifier. Information about NCCI-associated modifiers is included in the Correct Coding Initiative: National (correct) section in the appropriate Part 2 provider manual.

Brainteasers:

1. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 10, 2016. The cone biopsy was performed on January 17, 2016. 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? ____________

Answer Key: 1) 79; 2) 78
Evaluation and Management (E&M) Modifiers

E&M Examinations

Policy for Pre-Operative Visits Before or on the Day of Surgery
When performing a pre-operative visit on the day of or the day before a surgical procedure, the same primary or assistant surgeon must document medical justification in the Remarks field (Box 80) of the UB-04 claims form or the Additional Claim Information field (Box 19) of the CMS-1500 claim form. Exceptions to this policy may be made when the pre-operative visit is an initial emergency visit requiring extended evaluation or detention.

Postoperative
Office visits, hospital visits and consultations 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.

Code Exceptions

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 NCCI-associated</td>
<td>Unrelated E&amp;M service by the same physician during a postoperative period</td>
</tr>
<tr>
<td>25 NCCI-associated</td>
<td>Significant, separately identifiable E&amp;M service by the same physician on the same day of the procedure or other service</td>
</tr>
</tbody>
</table>

NOTE
Modifiers 24 and 25 require documentation.
Non-Physician Medical Practitioner (NMP)

Non-Physician Medical Practitioners (NMPs) include:

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

Codes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U7</td>
<td>Physician assistant service</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
</tr>
<tr>
<td>SB</td>
<td>Nurse midwife</td>
</tr>
</tbody>
</table>

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.

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 modifiers 80 and 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. Separate reimbursement is not made for physician supervision of an NMP.

NMP Services Claim Examples

Sample: Partial CMS-1500 Claim Form
Surgical Modifiers

January 2016

Sample: Partial UB-04 Claim Form

Anesthesia Related Drugs and Supplies Modifiers

<table>
<thead>
<tr>
<th>Codes</th>
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<tbody>
<tr>
<td><strong>Modifier</strong></td>
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<tr>
<td>UA</td>
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<tr>
<td>UB</td>
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</tbody>
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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.
Surgical Modifiers

HIPPA Code Conversion for Local Modifier ZS

On August 1, 2015, DHCS discontinued local modifier ZS (professional and technical component). When billing for both the professional and technical components, a modifier is neither required nor allowed per HIPAA compliance and CMS guidelines.

The termination of local modifier ZS affects claims and TARs for all split-billable procedures except for MRI, MRA and PET procedures. See the relevant sections of the Part 2 Medi-Cal Billing and Policy manual for details pertaining to the use of modifiers for MRI, MRA and PET procedures.

Claim Completion

Physician Billing: The physician bills for both the professional (26) and technical (TC) components and then reimburses the facility for the technical component (TC), according to their mutual agreements.

A CMS-1500 claim form is completed with the procedure code on one claim line and without a modifier in the Procedures, Services or Supplies/Modifier field (Box 24D).

Facility Billing: The facility bills for both the technical (TC) and professional components (26) and then reimburses the physician for the professional component, according to their mutual agreements.

A UB-04 claim form is completed with the procedure code on one claim line and without a modifier in the HCPCS/Rate/HIPPS Code field (Box 44).
Attachments – By Report

Attachment Requirements
The following is a list of Medi-Cal services that require “By Report” attachments:

- Surgical procedures
- Complicated procedures
- Unlisted services
  - No specific CPT-4 description of service
  - Requires a TAR
  - Time involved
  - Nature and purpose of procedure
  - Relation to diagnosis
- Anesthesia time

Documentation Requirements
The following is a list of required “By Report” documentation:

- Patient’s name
- Date of service
- Procedure code
- Operative report
- Estimated follow-up days
- Size, number and location of lesions (if applicable)
Learning Activities

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%
   c. Both

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. What modifier do I use if both the professional and technical components were performed after August 1, 2015?
   a. 26
   b. ZS
   c. TC
   d. None

6. For dates of service on or after October 1, 2015, providers should use the letter “O” to document the ICD indicator?
   a. True □
   b. False □

Answer key: 1) b; 2) a; 3) c; 4) a; 5) d; 6) b