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
- 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
- Review Common Denials

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:
  - Anesthesia-related Drugs & Supplies: UA, UB
  - Evaluation and Management: 24, 25
  - General Use: 22, 26, 52, 54, 55, 62, 66, 78, 79, 99
  - Non-Physician Medical Practitioner: AS, SA, SB, U7, U9
  - Radiology: 26, TC

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.
Surgical Modifiers

Claim Form Placement

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

<table>
<thead>
<tr>
<th>MM</th>
<th>DD</th>
<th>YY</th>
<th>To</th>
<th>YY</th>
<th>MM</th>
<th>DD</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>11</td>
<td>16</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td>NPI</td>
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</tbody>
</table>

Sample: Partial CMS-1500 Claim Form

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>101116</td>
</tr>
</tbody>
</table>

Sample: Partial UB-04 Claim Form

Surgical Procedures with Modifiers

Primary Surgeon Modifiers and Descriptions

<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>

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.

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.

Gender Dysphoria
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.

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 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 a non-indwelling or temporary indwelling 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 00100 – 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 Correct Coding Initiative: National (correct) section of the Part 2 provider manual.

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.
Claim Form Examples Using Modifier 50

Sample: Partial CMS-1500 Claim Form

Sample: Partial UB-04 Claim Form

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.

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.

Sample: Partial CMS-1500 Claim Form
**Sample: UB-04 Claim Form**
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 vs Modifier 99
- Modifier 51 describes second, third or subsequent differing procedures.
- Modifier 99 describes third and subsequent identical procedures.

Assistant Surgeon Modifiers and Descriptions

<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>

**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 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.

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

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Procedure Code</th>
<th>Description</th>
<th>Primary Diagnosis Code</th>
<th>Revenue Code</th>
<th>Diagnosis Code</th>
<th>Diagnosis Code 2</th>
<th>Hospital/Physician Number</th>
<th>Service Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 01 15</td>
<td>28220 080</td>
<td>Bunionectomy, RT Foot</td>
<td>100115</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 01 15</td>
<td>28220 099</td>
<td>Bunionectomy, LT Foot</td>
<td>100115</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 01 15</td>
<td>28090 99</td>
<td>Excision of Lesion</td>
<td>100115</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sample: Partial UB-04 Claim Form

<table>
<thead>
<tr>
<th>Procedure Code</th>
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<th>Description</th>
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<tr>
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<td>Bunionectomy, RT Foot</td>
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<tr>
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<td>2345678902</td>
<td>10 01 15</td>
<td>Excision of Lesion</td>
<td>100115</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

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_Surgical Modifiers_
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>PL A</th>
<th>PL B</th>
<th>PL C</th>
<th>PL D</th>
<th>PL E</th>
<th>PL F</th>
<th>PL G</th>
<th>PL H</th>
<th>PL I</th>
<th>PL J</th>
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</thead>
<tbody>
<tr>
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### Preferred Billing Method

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<th>PL D</th>
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<td>60000</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**UB-04 Form**

### Current Billing Method

<table>
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<th>PL D</th>
<th>PL E</th>
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<th>PL H</th>
<th>PL I</th>
<th>PL J</th>
</tr>
</thead>
<tbody>
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<td>AG</td>
<td></td>
<td>021116</td>
<td>1</td>
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<td></td>
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<td>51</td>
<td>20000</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
<td>15003</td>
<td>51</td>
<td>20000</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15003</td>
<td>51</td>
<td>20000</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Preferred Billing Method

<table>
<thead>
<tr>
<th>PL A</th>
<th>PL B</th>
<th>PL C</th>
<th>PL D</th>
<th>PL E</th>
<th>PL F</th>
<th>PL G</th>
<th>PL H</th>
<th>PL I</th>
<th>PL J</th>
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</thead>
<tbody>
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<td>15002</td>
<td>AG</td>
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<td>15003</td>
<td>51</td>
<td></td>
<td>021116</td>
<td>3</td>
<td>60000</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 and Descriptions

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

**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
- Irradiation
- 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.
Additional Surgeon(s) Modifiers

<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>

**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.

**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 instructions for modifier 66 permit each physician of a surgical team to bill separately for their services. However, when billing Medi-Cal, the services of all physician members of team must be billed on a single line of the same claim form.
Operative/Postoperative Modifiers and Descriptions

<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>

**Reduced Services (Modifier 52)**

**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-4 codes 15002 – 15429 and 52601 to address subsequent part(s) of a staged procedure.
Additional Operative Procedure Modifiers and Descriptions

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78</td>
<td>NCCI-associated</td>
</tr>
<tr>
<td>79</td>
<td>NCCI-associated</td>
</tr>
</tbody>
</table>

**Modifier Descriptions**

**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.

Discontinued Procedure Modifiers and Descriptions

<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 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</td>
</tr>
<tr>
<td>74</td>
<td>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</td>
</tr>
</tbody>
</table>

Knowledge Review

1. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 10, 2017. The cone biopsy was performed on February 17, 2017. 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 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.

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 reimbursable 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.

Exceptions

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>NCCI-associated Unrelated E&amp;M service by the same physician during a postoperative period</td>
</tr>
<tr>
<td>25</td>
<td>NCCI-associated 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)
- Licensed Midwife (LM)

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AS</td>
<td>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</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. 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)</td>
</tr>
<tr>
<td>U7</td>
<td>Used to denote services rendered by physician assistant (PA)</td>
</tr>
<tr>
<td>U9</td>
<td>Used to denote services rendered by licensed midwife (LM)</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**

<table>
<thead>
<tr>
<th>SEQUENCE</th>
<th>DESCRIPTION</th>
<th>HCPCS-UPC CODE</th>
<th>DATE PERFORMED</th>
<th>TOTAL CHARGES</th>
<th>AMOUNT PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COLPOSCOPY</td>
<td>57452SA</td>
<td>021116</td>
<td>27500</td>
<td></td>
</tr>
</tbody>
</table>

### Sample: Partial UB-04 Claim Form
Anesthesia-Related Drugs and Supplies Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UA</td>
<td>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.</td>
</tr>
<tr>
<td>UB</td>
<td>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.</td>
</tr>
</tbody>
</table>

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, 36299)
  - No specific CPT-4 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 stating the time involved, the nature and purpose of procedure/service and how it relates to diagnosis
- Estimated follow-up days
- Size, number and location of lesions (if applicable)

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.
## Common Denials

<table>
<thead>
<tr>
<th>RAD Code</th>
<th>Description</th>
<th>Follow-Up Procedure</th>
</tr>
</thead>
</table>
| 0196     | This procedure requires a modifier; modifier is not present | • Rebill the claim within six months from the month of service  
• Submit a *Claims Inquiry Form (CIF)* within six months from the denial date (date on RAD)  
• Submit an Appeal within 90 days from the denial date (date on RAD) |
| 0326     | Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service | • Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9068     | Submit documentation indicating the procedure performed was unilateral or bilateral | • Rebill the claim within six months from the month of service  
• Submit a *Claims Inquiry Form (CIF)* within six months from the denial date (date on RAD)  
• Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9106     | This modifier requires a breakdown (for example, 99 = 80 + 51) | • Rebill the claim within six months from the month of service  
• Submit a *Claims Inquiry Form (CIF)* within six months from the denial date (date on RAD)  
• Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9118     | This modifier is not payable without a primary surgeon modifier | • Rebill the claim within six months from the month of service  
• Submit a *Claims Inquiry Form (CIF)* within six months from the denial date (date on RAD)  
• Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9940     | NCCI (National Correct Coding Initiative) claim line is billed with multiple NCCI modifiers | • Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9941     | NCCI (National Correct Coding Initiative) column 2 procedure code is not allowed when column 1 procedure has been paid | • Submit an Appeal within 90 days from the denial date (date on RAD) |
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%
   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. 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

6. When billing for Physician Assistant (PA), what modifier should be used?
   a. 80
   b. U7
   c. 99 = (U7 + 80)
   d. None

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