In reviewing a recent claim denial report it is apparent that modifiers continue to be a source of confusion for our providers. Modifiers are required on many CPT codes, they tell the story of the procedure performed in more detail. The modifiers used directly affect the payment you receive for that procedure so you want to be as accurate as possible when adding them. Many procedures require a modifier for payment.

Listed below are some of the categories that require modifiers and the most used modifiers:

I. CPT codes in the 10000 to 69999 range there are several modifier choices. The most common are:
   a. AG- Indicating the primary surgeon
   b. 80- Indicating the assistant surgeon, refer to the Medi-cal manual for modifier usage, as Medi-cal does not allow assistant surgeons on many of the procedures that commercial insurances allow.
   c. 50- To be used when billing for bilateral procedures
   d. 51- For multiple procedures at the same session.
   e. Bill surgical supplies using “UA” non-general anesthesia or “UB” general anesthesia.

II. CPT codes in the 70000 to 79999 and 80000 to 89999 ranges usually require modifiers
   a. TC for the technical component and modifier
   b. 26 for the professional component.
   c. X-rays can also need a “RT” or “LT” modifier.
   d. Not all lab or x-ray codes are split billable, meaning they do not need a modifier at all, because just performing the procedure covers both the technical and professional components. Refer to the Medical Manual for lists of the non-split billable codes for each category.

III. E & M codes ranging from 99201 to 99499 can have a modifier added to better explain the situation under which this visit occurred. For example “25” denotes a visit that is separate from other services performed on the same day by the same physician. Modifier “SA” indicates a nurse practitioner and “SB” a nurse midwife.

IV. Immunizations that are NOT part of a CHDP exam and are billed with CPT codes need modifier “SL” meaning state supplied or “SK” indicating the patient is a member of a high risk group.

V. Anesthesia modifiers are in the “P1” to “P5” range based on the ASA ranking of the patient’s physical status.

A complete list of Medi-cal modifiers can be found in the Medi-cal manual and in the PHC manual. The various CPT code ranges and the use of modifiers is solely in the Medi-cal manual under each type of service; ie: surg bil mod would be entered in the search box in the provider manual section for you to see the modifiers required for surgical procedure codes.