



**Health Services Department (650) 616-2079**

**List of Procedures Codes Which REQUIRE a Modifier**

<b>CPT Procedure Codes</b>	<b>Most Commonly Used Modifiers</b>
00100 - 01999	AF, AG, P1-P5, ZA-ZJ, ZO, ZP, ZR, ZT, ZY
10000 - 69990	ZK, ZM, ZN, 80, 51, 50
70000 - 79999	ZK, ZM, ZN, 80, 51, 50
80000 - 89999	26, 90, 99, TC, ZS
90632-90634, 90636, 90645-90648, 90657-90659, 90669-90702, 90705-90707, 90712, 90713, 90716, 90718, 90720, 90721, 90723, 90743, 90744, 90746, 90748	SL
90632-90634, 90636, 90657-90659, 90665, 90675, 90676, 90690-90693, 90704, 90717, 90725, 90727, 90732, 90733	SK
90632-90634, 90636, 90657-90659	SK, SL
91000-91033, 91052-91065, 91122, 91132-91133	TC, ZS, 26, 99
92541-92547, 92585	TC, ZS, 26, 99
92978, 92979, 93024, 93025, 93268, 93281-93312, 93315, 93318, 93320-93501, 93505-93533, 93555, 93556, 93561, 93562, 93600, 93602, 93603, 93609-93613, 93615-93622, 93624, 93631-93642, 93662, 93724-93736, 93741-93744	TC, ZS, 26, 99
93875-93981, 93990	TC, ZS, 26, 99
94010-94620, 94680-94750, 94770	TC, ZS, 26, 99
95805-95827, 95829, 95842, 95858-95875, 95900-95958	TC, ZS, 26, 99



## CPT Codes Requiring Modifier

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**All surgical procedure codes require a modifier. Failure to submit a modifier with a surgical procedure code will result in the claim being returned to the provider for correction.**

**Primary Surgeon/Podiatrist:**

ZK

The primary surgeon/podiatrist is required to use modifier ZK on the only or highest valued surgical procedure code (Z1200-Z1212, 10000-69999) being billed for the date of service. Modifier -ZK applies to any procedure in this code range wherever performed.

*NOTE: This does not include codes that require split-bill modifiers.*

**Multiple Primary Surgeons**

Two or more surgeons can use modifier ZK for the same patient on the same date of service if the procedures are performed independently and in different specialty areas. This does NOT include surgical teams or surgeons performing a single procedure requiring different skills. An explanation of the clinical situation and operative reports by ALL surgeons involved must be included with the claim.

**Bilateral Procedure: 50**

Use modifier 50 when bilateral procedures add significant time or complexity to patient care at a single operative session. To use modifier 50, identify the first procedure by its listed procedure code with modifier ZK for the primary surgeon. Identify the bilateral procedure on another claim and TAR line and add modifier 50 to the procedure code.

For bilateral procedures requiring a separate incision performed at the same operative session, providers should bill the first procedure on the first claim line with the appropriate CPT code followed by modifier ZK, which indicates that the procedure is the primary surgery. Providers should bill the second procedure on the next billing line with the appropriate CPT code followed by modifier 50, which indicates the procedure was bilateral.

**Multiple Surgical Procedures**

51

When multiple procedures are performed on the same day or at the same operative session, providers should identify the major procedure with the modifier ZK and identify the secondary, additional or lesser procedures by adding modifier 51 to the secondary procedure codes (with the exception of special circumstances when providers are instructed to use modifier 99).



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- "By Report" Billing:** The following CPT codes are billed "By Report:" 67314, 67316, 67320, 67331, 67334. Providers must attach an operative report to the claim as these claims will be suspended for medical review.
- Altered Surgical Field: 60** Modifier 60 may be billed when procedures involve significantly increased operative complexity and/or time in a significantly altered surgical field resulting from the effects of prior surgery, marked scarring, adhesions, inflammation, or distorted anatomy, irradiation, infection, very low weight (i.e. neonates and small infants less than 10 kg) and/or trauma (as documented in a recipient's medical record). Justification is required on the claim.
- Surgical Team: 66** The services of all physician members of a surgical team, including primary and assistant surgeons, must be billed on a single line of one claim form using the appropriate CPT code with modifier 66.
- EXCEPTION: Anesthesiologists should submit a separate claim using the appropriate five-digit anesthesia procedure code and modifier.
- Billing Multiple Modifiers** When two or more modifiers are necessary to completely delineate a service, use modifier 99 with the appropriate procedure code and explain the applicable modifiers in the Remarks area/Reserved For Local Use field (box 19) of the claim.
- Third and Subsequent Procedures** Modifier 99 also is used to indicate third and subsequent identical procedures. Modifier 51 is appropriate to indicate a second procedure and third or subsequent different procedures. However, if modifier 51 is used more than once to bill the same procedure code, it will appear to be a duplication.
- Hammertoe Operations** Use modifier 99 when billing third and/or subsequent hammertoe operations (28285).



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**"Each Additional" Codes** Primary surgeons should not bill primary surgeon codes 15000, 61712 and codes where the descriptor is "each additional" with modifier 99 when performed on the same day or at the same operative session as another surgery.

**Assistant Surgeons:** 80, 99 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 multiple surgical procedures identified by the use of modifier 99 (multiple modifiers). Include an explanation in the Remarks area/Reserved For Local Use field (box 19) of the claim for the modifiers that apply to each procedure.

**Physician Assistant:** Modifier AS is used to bill for a PA who serves as a first assistant in surgery under an approved supervising physician. The PA's services must be billed by the supervising physician with modifier AS and the appropriate surgical procedure code.