Surgery Billing Examples: UB-04

Page updated: August 2020

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-10-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® 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 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.

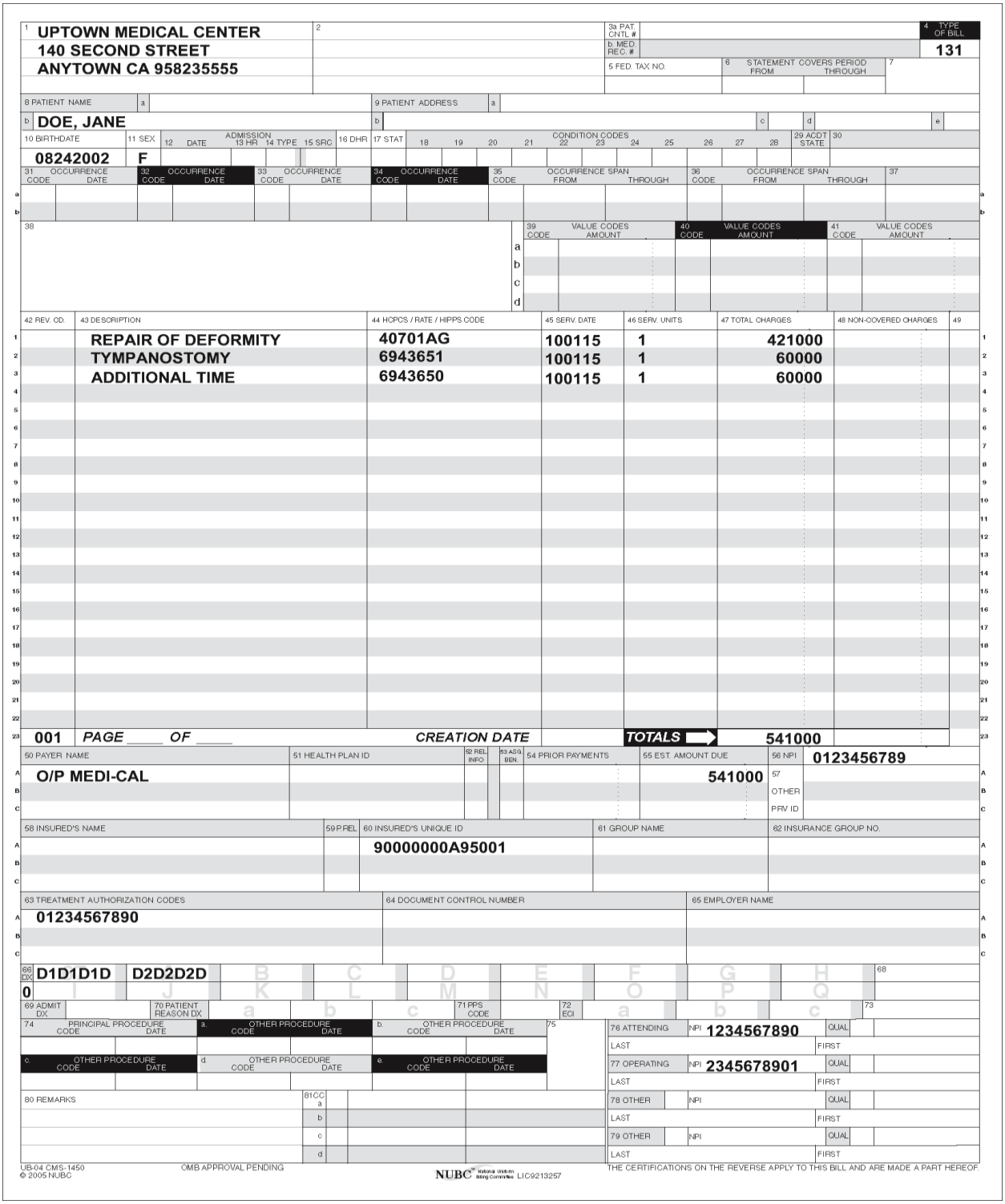
Enter the date of service for each entry in the *Service Date* field (Box 45) in the six-digit format. Enter a 1 in the *Service Units* field (Box 46) for each entry and the usual and customary charges in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) 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).

In this example, appropriate ICD-10-CM codes are entered in Box 67 for primary and secondary diagnoses.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

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).



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 131

8 PATIENT NAME: b DOE, JANE

10 BIRTHDATE: 08242002 | 11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	REPAIR OF DEFORMITY	40701AG	100115	1	421000	
	TYMPANOSTOMY	6943651	100115	1	60000	
	ADDITIONAL TIME	6943650	100115	1	60000	
23	001 PAGE ____ OF ____	CREATION DATE		TOTALS	541000	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 541000
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

63 TREATMENT AUTHORIZATION CODES: 01234567890

66 DX: D1D1D1D D2D2D2D
0

76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901

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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 code 28292 (correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method) 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 28292 with modifier AG (primary surgeon) in the *HCPCS/Rate* field (Box 44).

Line 2: Enter code 28292 with modifier 50 (bilateral procedure) in the *HCPCS/Rate* field (Box 44) to signify the procedure requires additional significant time.

Line 3: Enter code 28090 with modifier 51 (multiple procedures) in the *HCPCS/Rate* field (Box 44) to signify this is the secondary procedure.

Enter the date of service for each entry in the *Service Date* field (Box 45) in the six-digit format. 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).

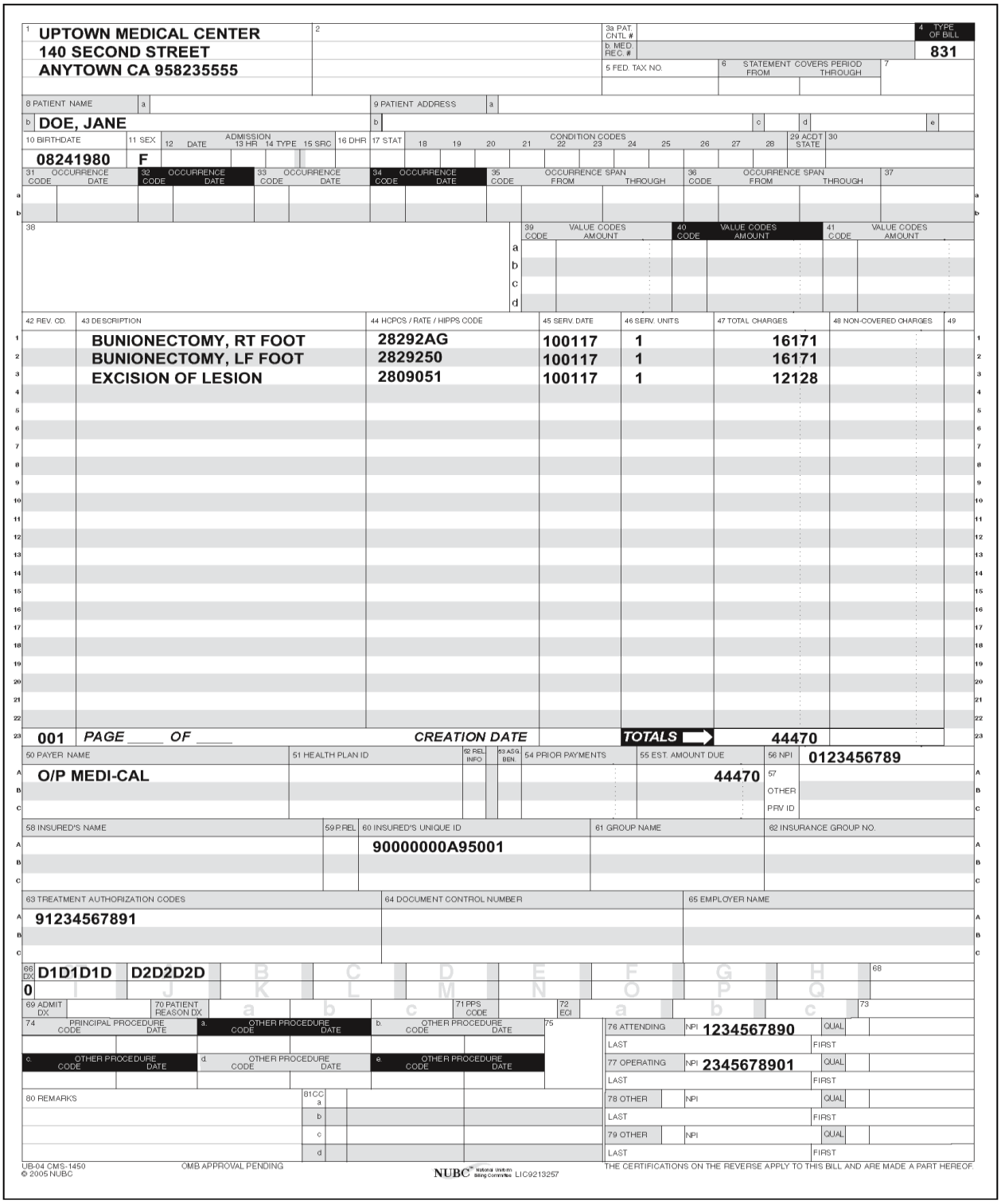
The surgery clinic's NPI number is placed in the *NPI* field (Box 56).

Enter the 11-digit TCN in the *Prior Authorization Number* field (Box 63).

In this example, appropriate ICD-10-CM diagnosis codes are entered in Box 67 for primary and secondary diagnoses.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

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).



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 831

8 PATIENT NAME: DOE, JANE
10 BIRTHDATE: 08241980
11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	BUNIONECTOMY, RT FOOT	28292AG	100117	1	16171	
2	BUNIONECTOMY, LF FOOT	2829250	100117	1	16171	
3	EXCISION OF LESION	2809051	100117	1	12128	
23	001 PAGE ____ OF ____	CREATION DATE		TOTALS	44470	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 44470
56 NPI: 0123456789
60 INSURED'S UNIQUE ID: 90000000A95001
63 TREATMENT AUTHORIZATION CODES: 91234567891
66 DX: D1D1D1D D2D2D2D 0
76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901

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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.

Enter the date of service for each entry in the *Service Date* field (Box 45) in the six-digit format. 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).

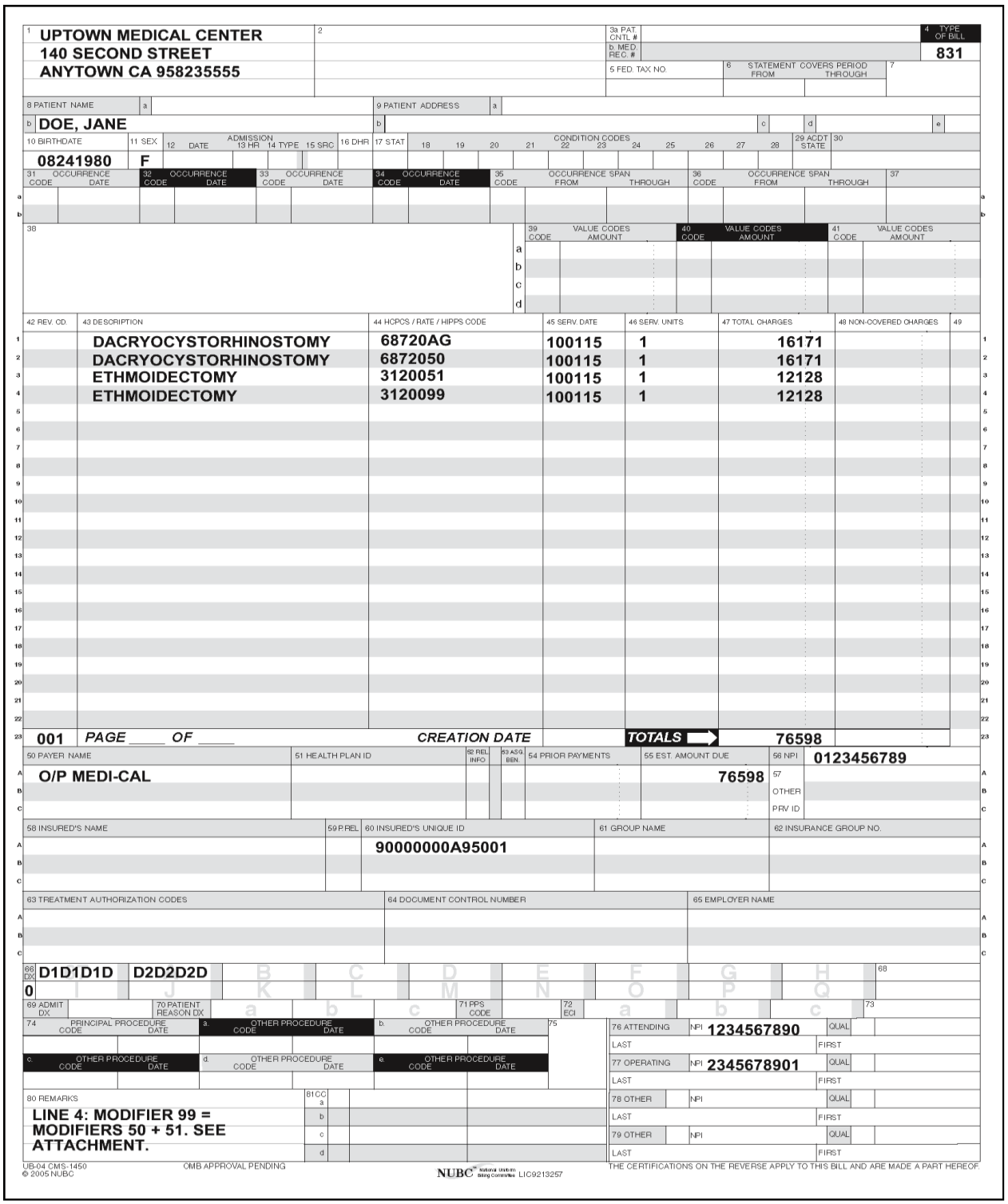
In this example, appropriate ICD-10-CM diagnosis codes are entered in Box 67 for primary and secondary diagnoses.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

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 "LINE 4: 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

4 TYPE OF BILL: 831

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 08241980 | 11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	DACRYOCYSTORHINOSTOMY	68720AG	100115	1	16171	
2	DACRYOCYSTORHINOSTOMY	6872050	100115	1	16171	
3	ETHMOIDECTOMY	3120051	100115	1	12128	
4	ETHMOIDECTOMY	3120099	100115	1	12128	
23	001 PAGE ____ OF ____	CREATION DATE		TOTALS	76598	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 76598
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D | D2D2D2D
0

76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901

80 REMARKS: LINE 4: MODIFIER 99 = MODIFIERS 50 + 51. SEE ATTACHMENT.

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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 code 28292 (correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method) 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 28292 with modifier 80 (signifying that an assistant surgeon rendered the service) in the *HCPCS/Rate field* (Box 44).

Line 2: Enter code 28292 with modifier 99 (signifying that the procedure is billed with multiple modifiers) in the *HCPCS/Rate* field (Box 44).

Line 3: Enter code 28090 (excision of lesion, tendon sheath, or capsule [including synovectomy] [eg, cyst or ganglion]; foot) with modifier 99 (signifying that the procedure is billed with multiple modifiers) in the *HCPCS/Rate* field (Box 44).

Enter the date of service for each entry in the *Service Date* field (Box 45) in the six-digit format. 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).

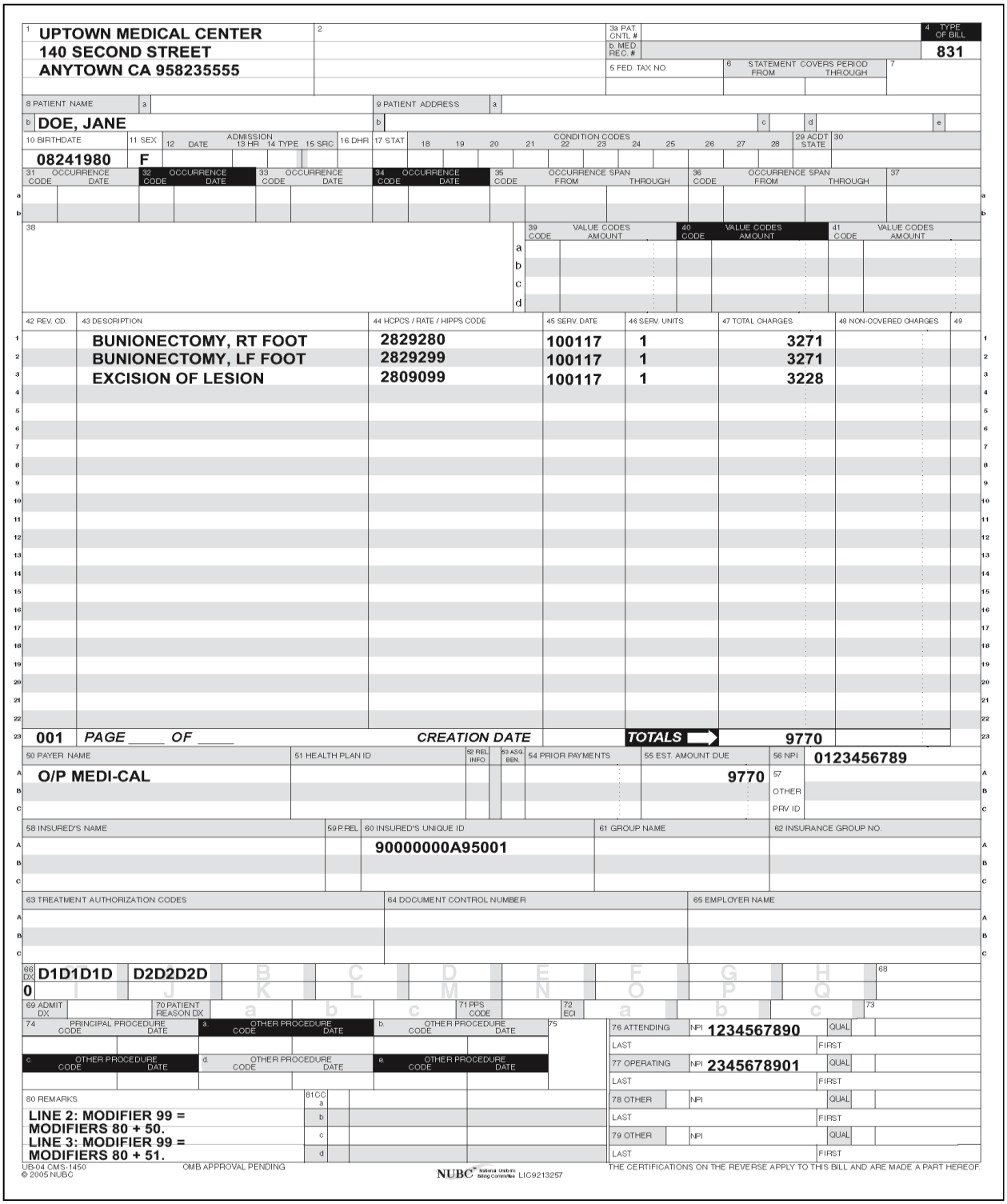
The surgery clinic's NPI number is placed in the *NPI* field (Box 56).

In this example, appropriate ICD-10-CM diagnosis codes are entered in Box 67 for primary and secondary diagnoses.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

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

4 TYPE OF BILL: 831

8 PATIENT NAME: DOE, JANE
10 BIRTHDATE: 08241980
11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	BUNIONECTOMY, RT FOOT	2829280	100117	1	3271	
2	BUNIONECTOMY, LF FOOT	2829299	100117	1	3271	
3	EXCISION OF LESION	2809099	100117	1	3228	
23	001 PAGE ____ OF ____	CREATION DATE		TOTALS	9770	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 9770
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D D2D2D2D
0

76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901

80 REMARKS:
LINE 2: MODIFIER 99 =
MODIFIERS 80 + 50.
LINE 3: MODIFIER 99 =
MODIFIERS 80 + 51.

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Figure 4: Modifiers 80 and 99.

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 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).

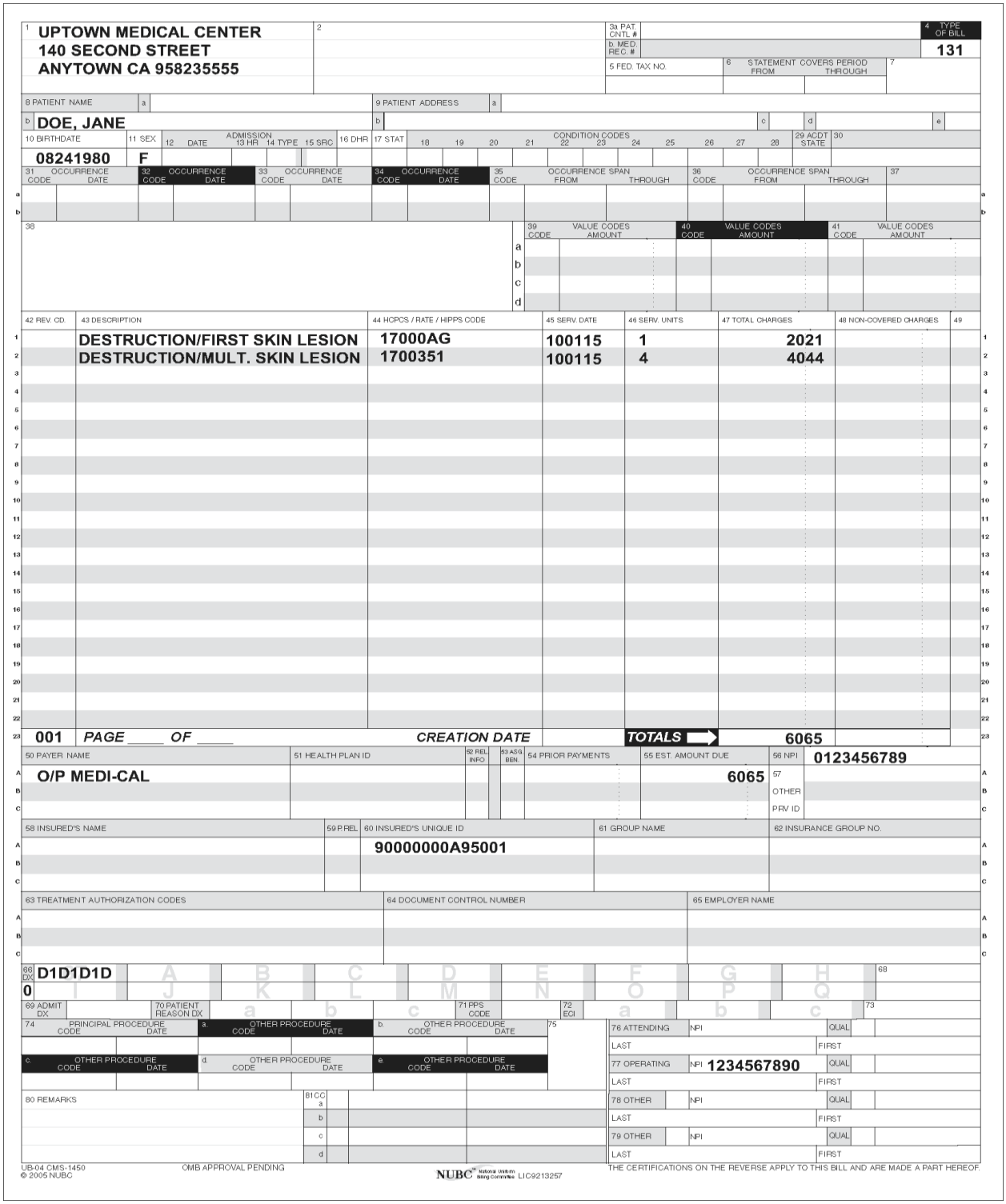
Enter the two-digit facility type code “13” (hospital – outpatient) and one-character claim frequency code “1” as “131” in the *Type of Bill* field (Box 4).

The date of service is entered for each entry in the *Service Date* field (Box 45) in the six-digit format. 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-10-CM diagnosis code is entered in Box 67. Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

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



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 131

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 08241980 | 11 SEX: F

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/FIRST SKIN LESION	17000AG	100115	1	2021	
2	DESTRUCTION/MULT. SKIN LESION	1700351	100115	4	4044	
23	001 PAGE ____ OF ____	CREATION DATE		TOTALS	6065	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 6065
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI
77 OPERATING NPI: 1234567890
78 OTHER NPI
79 OTHER NPI

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NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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).

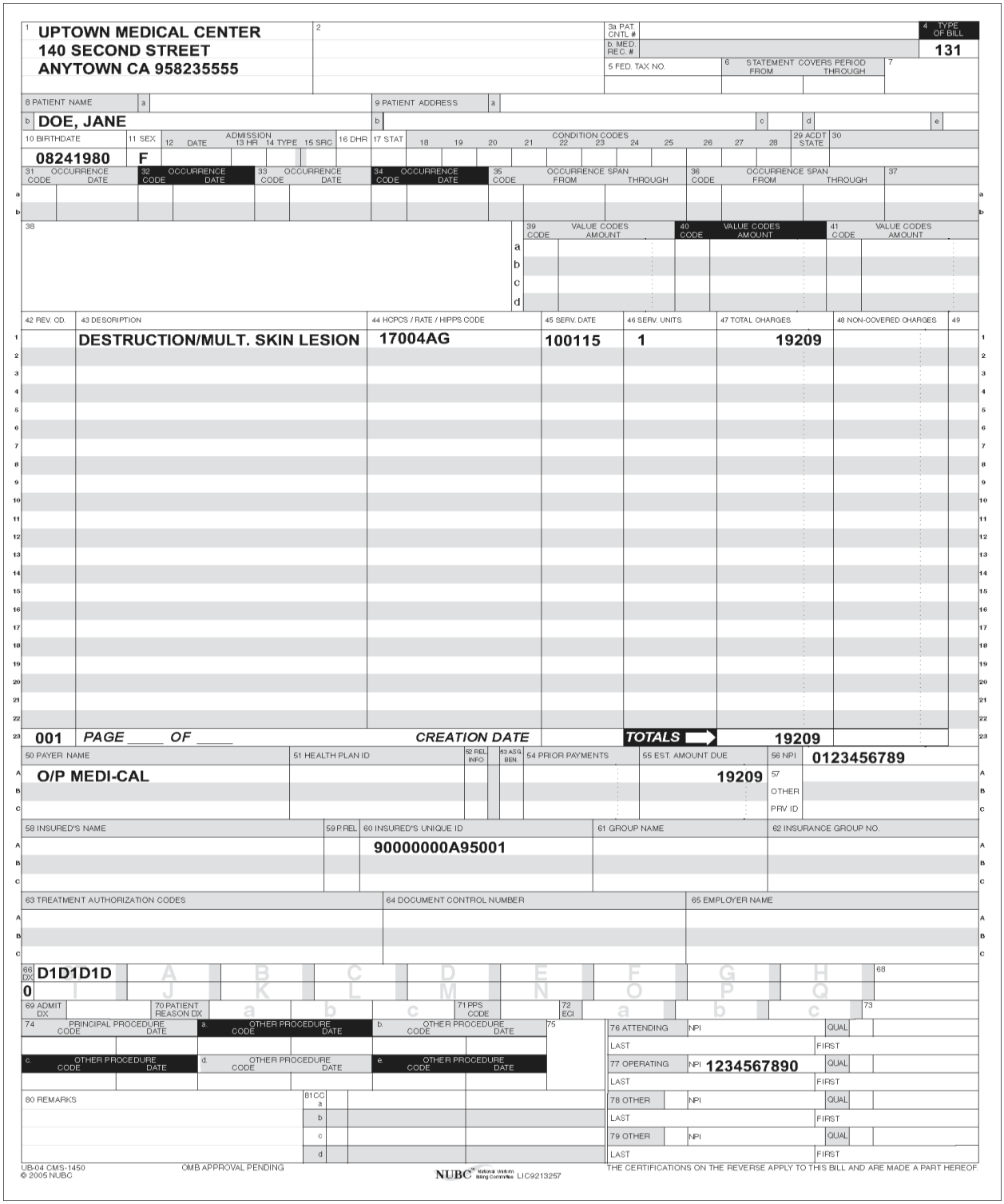
Enter the two-digit facility type code “13” (hospital – outpatient) and one-character claim frequency code “1” as “131” in the *Type of Bill* field (Box 4).

Enter the date of service in the *Service Date* field (Box 45) in the six-digit format. 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-10-CM diagnosis code is entered in Box 67. Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

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



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 131

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 08241980 | 11 SEX: F

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	100115	1	19209	
23	001 PAGE ____ OF ____	CREATION DATE		TOTALS	19209	

50 PAYER NAME: O/P MEDI-CAL | 55 EST. AMOUNT DUE: 19209 | 56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI | 77 OPERATING NPI: 1234567890 | 78 OTHER NPI | 79 OTHER NPI

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

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.