KERN HEALTH SYSTEMS

Modifiers and Diagnosis

Claims Informational Guide

Last Updated: February 18, 2026

Provider Training Guide: Coding, Modifiers, and Billing Guidelines

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1. Physician-Only Surgical Procedures

Key Requirement

- Applies to **CPT code range 10000–69999**.
- **All primary surgeries** → must include **AG modifier** in the first field (even if only one procedure is billed).
- **All secondary surgeries (including add-ons)** → must include **51 modifier** in the first field.
- **Examples:**
  CLAIM 1 EXAMPLE
- 43300 Esophagoplasty AG

  CLAIM 2 EXAMPLE
- 19000 Puncture aspiration of cyst of breast AG
- 19001 each additional cyst 51

  CLAIM 3 EXAMPLE
- 15100 Split-thickness autograft, trunk; first 100 sq cm or less AG
- 15101 each additional 100 sq cm 51
- 15155 Tissue cultured skin autograft, face, first 25 sq cm or less 51

. Repeat & Related Procedure Modifiers

Modifier 76 – Repeat Procedure by Same Provider

- **Use When:** Same procedure/service repeated on the same day by the same provider, for medical necessity.
- **Example:** Echocardiogram performed in the morning for chest pain, repeated later for change in symptoms.

Modifier 77 – Repeat Procedure by Different Provider

- **Use When:** Same procedure repeated on the same day by a different provider.
- **Example:** Emergency physician performs a chest X-ray; radiologist repeats later due to new findings.

Modifier 91 – Repeat Clinical Diagnostic Laboratory Test

- **Use When:** Medically necessary lab test repeated same day to obtain new results.
- **Do Not Use:**

    - For equipment/specimen failure.
    - When test is part of a panel already billed.
- **Example:** Blood glucose tests repeated throughout the day for diabetes monitoring.

Modifier 78 – Unplanned Return to OR

- **Use When:** Unplanned return to operating/procedure room during global period for related procedure due to complications.
- **Example:** Patient returned to OR for post-op bleeding control.

Modifier 58 – Staged/Related Procedure

- **Use When:** Planned, staged, or more extensive procedure during the postoperative period.
- **Example:** Scheduled skin graft following lesion excision.

Modifier 59 – Distinct Procedural Service

- **Use When:** To indicate procedures/services normally bundled are distinct (different site, encounter, or service).
- **Example:** Incision/drainage of abscess on arm and leg, same visit.
- ⚠️ Use with caution; highly audited. Consider **X-modifiers** (XE, XS, XP, XU) when appropriate.

Quick Reference Table

Modifier	Used For	Same Day?	Post-Op?	Same Provider?	Key Criteria
76	Repeat procedure	✅	❌	✅	Same provider, same day
77	Repeat procedure	✅	❌	❌	Different provider, same day
91	Repeat lab test	✅	❌	✅	Medically necessary
78	Return to OR	❌	✅	✅/❌	Complication, same global period
58	Staged procedure	❌	✅	✅	Planned or extensive procedure
59	Distinct service	✅	✅	✅	Different site/encounter/service

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3. Laboratory Codes: Not Split-Billable

Certain **HCPCS and CPT laboratory codes** must **not** be billed with modifiers **26, TC, or 99**.

Examples of Not Split-Billable Codes

- **HCPCS:** G0472 (Hepatitis C antibody screening), G0499 (Hepatitis B screening), G0659 (Drug testing, definitive)

- **CPT:** 80143 (Acetaminophen), 80165 (Valproic acid), 80305–80307 (Presumptive drug tests), 81025 (Urine pregnancy test), 81528 (Colorectal oncology screening), 81542 (Prostate oncology profiling), and many others.

📌 **Note:** For complete listing, refer to the "Not Split-Billable Codes Table" section of this guide.

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4. External Cause Diagnosis Codes

- **External Cause Codes (ICD-10-CM)** provide context for injuries/conditions but **cannot be used as the primary diagnosis** (except when part of Medi-Cal Community Support Services).

What They Provide

- **How:** Mechanism of injury.
- **Where:** Place of occurrence.
- **What:** Patient's activity.
- **Status:** Civilian, student, worker, etc.
- **Intent:** Accidental, intentional, assault, terrorism.

Example

- **Principal Diagnosis:** S86.011A – Strain of right Achilles tendon, initial encounter.
- **External Codes:**
    - W19.A – Fall, unspecified, initial encounter.
    - Y92.31 – Sidewalk, place of occurrence.
    - Y93.3 – Activity: Walking.
    - Y99.8 – Recreational activity, not for income.

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5. Manifestation Diagnoses

- **Definition:** Secondary conditions caused by an underlying disease.
- **Never coded as the primary diagnosis.**
- **Coding Order:** Underlying condition first → followed by manifestation.

Examples

- **Diabetes + Neuropathy** → Diabetes coded first; neuropathy coded second.
- **Diabetes + Cataracts** → Diabetes primary; cataract secondary.
- **Hypertension + Heart Failure** → Hypertension primary; heart failure secondary.

Coding Tips

- Look for ICD-10-CM phrases like *"in diseases classified elsewhere"* → indicates manifestation.

Summary

- **AG Modifier:** Required for all primary surgeries.
- **51 Modifier:** Required for all secondary/add-on surgeries.
- **Repeat/Related Modifiers (76, 77, 91, 78, 58, 59):** Use appropriately per scenario.
- **Not Split-Billable Labs:** Certain HCPCS/CPT codes cannot use 26, TC, or 99 modifiers.
- **External Cause Diagnoses:** Provide context, not primary diagnosis.
- **Manifestation Diagnoses:** Code underlying condition first, then manifestation.