Health Plan of San Mateo
Healthy is for everyone

801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080
tel 650.616.0050
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1
www.hpsm.org

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Using Modifiers on Claims for Repeat Services

Dear provider,

To ensure accurate and timely claims processing, the Health Plan of San Mateo (HPSM) is providing additional guidance on the correct use of modifiers. This guidance should be used when billing for the same procedure multiple times for the same member on the same date of service (DOS).

A denial can be expected if the same service is submitted on more than one claim or more than one claim line for the same DOS without utilizing the "Days/Units" field or appropriate modifier.

In Summary:

- Use repeat service modifiers (76, 77, 59, 91) when the same service is performed multiple times on the same day.
- Use anatomical modifiers when the procedure is performed on different body parts.
- Do not use modifier 59 when a more specific repeat or anatomical modifier is available.
- Claims missing required modifiers may be denied or subject to additional review.

When submitting claims for repeated procedures, the following CPT and HCPCS modifiers should be applied depending on situation:

Modifier	Description
Modifier 59	**Distinct Procedural Service (use only when none of the Modifiers in the rest of this table apply)**: Used when the repeated service is separate and distinct from the initial service and not normally reported together.

	Example: A provider performs ultrasound-guided joint injections at two different anatomical sites during the same visit. The second injection should be billed with modifier 59 if it is not typically bundled.
Modifier 76	**Repeat Procedure by Same Physician or Other Qualified Healthcare Professional:** Used when the same provider performs the same service more than once on the same day. Example: A provider performs chest X-rays (CPT 71046) at 10:00 AM and again at 4:00 PM for the same patient. The second service should be billed as 71046-76.
Modifier 77	**Repeat Procedure by Another Physician or Other Qualified Healthcare Professional:** Used when a different provider performs the same procedure on the same day. Example: A patient undergoes a Doppler ultrasound of the extremities (CPT 93925) in the morning performed by Dr. A. Later that day, the patient's condition changes, and another Doppler ultrasound is required and performed by Dr. B. The second service should be billed as 93000-77.
Modifier 91	**Repeat Clinical Diagnostic Laboratory Test:** Used when the same lab test is repeated on the same day for medical necessity (not due to lab error). Example: A glucose tolerance test requiring multiple blood draws throughout the day. Each repeat test should be billed with modifier 91 (e.g., 82947, 82947-91).
Site Modifiers	When billing procedures are performed on different anatomical sites, anatomical modifiers should be used to distinguish each service: - Eyelids: E1 – Upper left, E2 – Upper right, E3 – Lower left, E4 – Lower right

	- Fingers: FA – Left hand, thumb, F1-F5 – Left hand, index to little finger, F6-F9 – Right hand, index to little finger - Toes: Left foot- TA-T4/Right foot T5-T9 - LT / RT: Left or right Side of the body Example: - 28010 (Tenotomy, percutaneous, toe; single tendon)– T1

Billing guidance when billing multiple modifiers on a single line: Modifiers are grouped into categories based on their purpose. They should generally be listed in the following order when billing HPSM.

- 1st: Pricing modifiers impacting payment or processing (e.g., -26, -TC, -51, -50).
- 2nd: Informational modifiers (e.g., -59, -76, -77, -91).
- 3rd: Anatomical modifiers used to provide additional context but don't typically impact payment (e.g., -RT and -LT).

What to do if your claim is denied and the modifier was inadvertently left off: Rebill the claim with the modifier appended to the service line. More information regarding corrected claims is available here: **https://www.hpsm.org/provider/claims/update-claims**

For further assistance, please contact the Claims Department at **650-616-2106** or **ClaimsInquiries@hpsm.org.**

Thank you,
The Health Plan of San Mateo