Part B Education Exclusive:
Modifier 59 Edit Update

Presented By: Part B Provider Outreach & Education
Cahaba GBA would like to provide some clarification of the use of Modifier 59. The modifier is not limited to National Correct Coding Initiative (NCCI) pairs. We apologize for any confusion our July article may have caused. Modifier 59 can be used when medical necessary to report claims with two different procedure codes that are not normally reported together. The rules for Modifier 59 usage remains the same. Modifier 59 is not appropriately filed when it is used to indicate that a single procedure code was performed more than once per day. In this instance, modifier 76 or an anatomical modifier is the appropriate modifier to indicate that the same procedure code was repeated more than once per day.

Providers should check the NCCI edits prior to claims submission to verify if appending any modifier is appropriate. Other modifiers are also available to report repeat services by the same physician subsequent to a service or procedure (modifier 76), repeat laboratory tests performed on the same day (modifier 91) as well as diagnostic and anatomical modifiers (modifier(s) LT, RT, 50, E1 –E4, FA, F1-F9, TA and T1-T9) can be used when appropriate.

It is ultimately the billing providers/suppliers responsibility to ensure the correct coding of the medical claims submitted to Medicare for reimbursement. All informational examples used during the presentations were for educational purposes only.
**Part B Education Exclusive: Modifier 59 Edit Update Questions**

**All of the following questions were captured during the Modifier 59 Edit Update Webinars. These questions were submitted in by the provider community in the Telspan Text Chat Messaging Area and the Event Evaluation free form area.**

**General**

- I want to verify that Anatomical Modifiers are NOT used on E & M claims. That they are for surgical procedures only?
  
  **A:** Anatomical Modifiers are only appropriate on procedures and services, not diagnosis codes or Evaluation and Management codes.

- Occasionally it is appropriate to bill a code more than once even though there is an MUE. We were told in past to use modifier 59 with the two tests on separate lines to override the MUE edit. Does that still apply? When is it appropriate to bill? What will change?
  
  **A:** The rules for Modifier 59 usage have not changed. The provider should check NCCI edits prior to claims submission to verify if appending any modifier to their claim is appropriate/allowed. Modifier 59 has no impact to the processing of a service in relationship to an MUE value and is not appropriate in those situations.

- Is the AMA going to clarify his in the CPT modifier descriptions since it does not indicate that repeat procedure would not need to be in the exact same area?
  
  **A:** The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association. Inquires or changes concerning CPT can be addressed by submitting a Coding change request form and are available through the AMA and their website.
• Effective July 1st, 2013..... does this begin with claim dates of service (DOS) and on?  What about a claim with date of service 6/30/2013?
   A: All claims received for process on July 1st, 2013, regardless of date of service will be subject to the changes to the exact duplicate edit.

• How does the repeat procedure modifier affect payment?
  A: It does not affect payment.

• I work for a hospital and wondered if this change is going to affect our UB04 claims?
  A: This change does not affect Part A claims.

• If you have two (2) separate surgery codes performed on the same day of service, do you continue to use Modifier 59?
  A: The rules for Modifier 59 usage have not changed. The provider should check NCCI edits prior to claims submission to verify if appending any modifier to their claim is appropriate/allowed.

• We are already receiving denials with the LT, RT, and 50 modifiers for bilateral mastectomy.  What will happen with this new edit system?
  A : Providers should use Modifier 50 instead of RT/LT in most cases where the service is a true bilateral, as is the case with bilateral mastectomy.  Check out the Medicare Physician Fee Schedule on our website under the Relative Value File. You can search for procedure codes that have a bilateral indicator value of “1” to see which procedure codes can appropriately be filed with modifier 50 instead of RT/LT.
• What does only “re-file denied services” mean?
  A: If you submit a claim with more than one service line, and the claim system processes one service line and denies the subsequent line/s, you should only resubmit the service line on the claim that was denied.

• If you have more than one surgery code for the same day of service, which code do you use? Do we continue to use 59?
  A: The rules for Modifier 59 usage have not changed. The provider should check NCCI edits prior to claims submission to verify if appending any modifier to their claim is appropriate/allowed. Modifier 59 would not appropriately be filed if it is used to indicate that a single procedure code was performed more than once per day (repeat service). Modifier 76 or an anatomical modifier is the appropriate modifier to indicate that the same procedure code was repeated more than once per day.

• What about when Medicare is secondary? Commercial insurance carriers do not recognize the 76 modifier in the same way as Medicare?
  A: The submission of modifier 76 to Medicare Secondary is not any different than other Medicare Secondary situations. You must file the claim to the primary insurer as they require and then you must submit the secondary claim to Medicare based on proper filing for Medicare services.

• Anatomical modifiers with the same procedure codes times two (2), do you now want the use of the 76 modifier and the correct multiple anatomical modifiers, or the 59 modifier to identify separate anatomical site.
  A: Modifier 59 should not be used to indicate that a procedure code was performed more than once per day. If the same procedure code is performed more than once and there are anatomical modifiers to indicate that the services were performed in different sites, then those should be used. If there is no anatomical modifier to indicate that the procedure was performed
more than once on the same day, then modifier 76 would be necessary to show that the procedure is a repeat.

**Anesthesia**

- If a patient is taken to surgery twice on the same date of service, we have been using the modifier 59 on the second Anesthesia case. Is this still correct?
  
  A: Modifier 59 is not appropriate to indicate that the same procedure was performed more than once per day. If the same anesthesia procedure is performed more than once per day, then modifier 76 would need to be appended to the procedure in addition to the appropriate anesthesia modifiers.

**Cardiology**

- If you have two identical CPT codes and they are billed along with other CPT codes and are bundled to one of the other CPT codes billed on the same claim. Would you use the 59 on the first code and then a 59 and 76 on the other code? Example: 32551-59; 32551-59, 76.
  
  A: Yes, this would be an appropriate use of modifier 59 and 76, as long as there is a separate “bundled” procedure code being filed for the same date of service.

**Dermatology**

- When billing lesions with the same proc code, is the 76 modifier appropriate? Example: 11623, 11622, 11622-76, 11413, 11423-76.
  
  A: Yes, it is appropriate to use modifier 76 on surgical services when the same procedure is performed more than once per day and there is not an anatomical modifier that can be utilized.
You mentioned that modifier 76 is not limited to the same site, so when removing multiple benign lesions from separate sites that meet the definition of modifier 59 on different sites. For the scenario of two lesions removed (same anatomical area but two locations i.e.: Same type of lesion) would it be appropriate to use units on the claim? Then there is no need for the CPT code to be submitted twice with Modifier 76.

A: Removal of multiple lesions from separate sites will never meet the definition of modifier 59 when the same procedure code is being filed. Modifier 59 is to be used for a “code pair” from the NCCI to indicate that the procedures should both be allowed due to them being performed in different anatomical sites or different times of day.

Some surgical procedures can be filed with multiple units of service and others cannot. This can be determined be referring to the Medicare Physician Fee Schedule section of our website under the Relative Value file. A surgical procedure with a multiple surgery indicator of 0, is acceptable to be filed with multiple units of service. Any multiple surgery indicator other than 0, can only be filed as a single unit of service per line item.

We are a dermatology practice. When we use 11401 on 3 lines (procedures done in 3 separate sites - 3 separate excisions) it appears the info on modifier 59 would apply - modifier 59 exceptions. Here is another scenario - CPT 17311 on 2 lines - surgery done on 2 separate areas, neither of these examples are “repeat” nor “subsequent”. Modifier 76 does not seem appropriate based on Modifier 59 criteria and per CPT guidelines.

A: Removal of multiple lesions from separate sites will never meet the definition of modifier 59 when the same procedure code is being filed. Modifier 59 is to be used for a “code pair” from the NCCI to indicate that the procedures should both be allowed due to them being performed in different anatomical sites or different times of day.
We are a dermatology practice and often use the exact same codes but they are performed on separate areas, separate lesions. Example: 17311 on the head and 17311 on the hand. They are NOT subsequent procedures so I don’t feel 76 modifier is correct, they are NOT repeat procedures. They are procedures performed that appear to hit the modifier 59 exceptional circumstances. Can you clarify? We went through this same issue about 3 years ago, and it finally went away with Medicare.

A: Modifier 76 definition does not state that this is a repeat procedure in the exact same area. The modifier 76 indicates that this is a repeat of the same procedure on the same date of service. A procedure is identified by the CPT code description, absent of any modifiers. Therefore, if you perform the same “procedure” in multiple locations, modifier 76 is appropriate.

Removal of multiple lesions from separate sites will never meet the definition of modifier 59 when the same procedure code is being filed. Modifier 59 is to be used for a “code pair” from the NCCI to indicate that the procedures should both be allowed due to them being performed in different anatomical sites or different times of day.

I feel the Medicare’s new guidelines on the use of modifier 59 do not coincide with CPT guidelines when used in scenarios such as multiple lesions removal. If you removed a lesion on the arm and another on the leg of the same size, CPT states you should use a modifier 59 on the second lesion removal due to separate anatomic sites. Example: 11401, 11401-59, also, would this apply to two separate angioplasty in different vessels of the same leg? Would modifier 76 truly be appropriate when it is not a repeat procedure?

A: Modifier 76 definition does not state that this is a repeat procedure in the exact same area. The modifier 76 indicates that this is a repeat of the same procedure on the same date of service. A procedure is identified by the CPT code description, absent of any modifiers. Therefore, if you perform the same “procedure” in multiple locations, modifier 76 is appropriate.

Removal of multiple lesions from separate sites will never meet the definition of modifier 59 when the same procedure code is being filed. Modifier 59 is to be used for a “code pair” from the NCCI to indicate that the procedures should both be allowed due to them being performed in different anatomical sites or different times of day.
• If my dermatologist does 4 skin biopsies, I would normally code 11100 & then 11101 with 3 units. Sometimes, I list the 11101 on separate lines because the diagnosis may be different for each biopsy. Would I bill 11101 first with no modifier, but then bill the next two 11101 with modifier 76?

    A: If you normally file multiple units of service, then we are not indicating that you need to change how you normal submit your claims. However, if you do file the same procedure code on more than one line item, then yes, you would file the first line without a modifier and the subsequent line items with modifier 76.

• My facility is an ASC and frequently bills the same procedure code multiple times due to excision of Lipomas from different sections of arms, legs, etc. We have been billing with a 59 modifier, uncertain but believe that a 76 should be utilized now. RT and LT are not accepted by Medicare for ASC's moreover frequently there may be 5 separate sites on one arm where Lipomas are removed and sutured.

    A: Yes, modifier 76 would be appropriate on the subsequent line items that have the same procedure code. The first line item would not contain a modifier 76.

• If you have nine (9) excisions on one patient, all different locations but different CPT levels of excision example: 11404 x 1, 11403 x 3, and 11401 x 2. Do I use a 59 modifier on all?

    A: You would need to refer to NCCI edits to determine if any of the code pairs you are filing are classified as “bundled” procedures.

• This program was very good but it did not address how we are supposed to proceed when Medicare is secondary and the commercial insurance carrier will not recognize the same coding pattern as Medicare, i.e. they will not recognize a modifier 91 on pathology codes such as 88305 or a 76 on procedure codes such as 11300. How are we to overcome this difficulty with EOBs that will not match? Will Medicare process appropriately? In the past this has led to non-payment and a lot of work on our part to attempt to collect outstanding balances.
**Lab/Pathology**

- Cytopathology codes describe varying methods of preparation and examination of different types of specimens. For a single specimen, only one code from a group of related codes describing a group of services that could be performed on the specimen with the same end result (e.g., 88104-88112, 88142-88143, 88150-88154, 88164-88167, etc.) should be reported. If multiple services (i.e., separate specimens from different anatomic sites) are reported, modifier 59 should be utilized to indicate that different levels of service were provided for different specimens from different anatomic sites. 


A: The rules for Modifier 59 usage have not changed. The provider should check NCCI edits prior to claims submission to verify if appending any modifier to their claim is appropriate/allowed. The modifier 59 is not appropriately filed when it is used to indicate that a single procedure code was performed more than once per day (repeat service). Modifier 91 or an anatomical modifier is the appropriate modifier to indicate that the same procedure code was repeated more than once per day.

- If we have more than 2 of something (i.e., clotting times 85347 done 4 times)—does each procedure need to be on separate lines (as indicated in the memorandum sent to us) or just 2 lines with 1 on 1st line and 3 on 2nd line with the modifier 91?

A: Our instructions do not change the way you file multiple units of service. Our instructions simply indicate that modifier 59 cannot be used as a repeat modifier when a procedure code is filed more than one time per day. Modifier 91 would need to be utilized if the same laboratory procedure is filed more than once per day.
For drug screen billing would we use a 91 or 76?

A: Modifier 91 would be utilized on lab procedure codes that are filed more than once per day.

Guidelines say “If billing a procedure code 2 or more times, same date, claim should have procedure code listed on one line without modifier and each subsequent procedure listed on a separate line. So if I have 84484 x 3, do we put on 2 lines or 3?

A: Our instructions do not change the way you file multiple units of service. Our instructions simply indicate that modifier 59 cannot be used as a repeat modifier when a procedure code is filed more than one time per day. Modifier 91 would need to be utilized if the same laboratory procedure is filed more than once per day.

Musculoskeletal

I work in an orthopedic practice. In some cases, the physician does injections in both knees. We typically bill the first code with RT or LT modifier and then the second code with 59, RT or LT. Should this be billed with 76, RT or LT even though the injection was done in another anatomic site?

A: Modifier 59 should not be used to indicate that a procedure code was performed more than once per day. If the same procedure code is performed more than once and there are anatomical modifiers to indicate that the services were performed in different sites, then those should be used. If there is no anatomical modifier to indicate that the procedure was performed more than once on the same day, then modifier 76 would be necessary to show that the procedure is a repeat.

We file procedure 20610. Sometimes it's bilateral knee injection with 20610-50 with DX-715.16 (for knee) and then on same day- we may also do a shoulder injection 20610-59 with DX 715.11. One or the other gets denied as duplicate when there are two different diagnosis codes. Have we been filing correctly or are you saying we should be using 76, RT, LT making a 3 line item as: 20610-RT DX 715.16 (knee)
and then what if we do bilateral knees and bilateral shoulders-- would it be:
20610-LT-76 DX 715.16
20610-RT-76 DX 715.11

A: Modifier 59 should not be used to indicate that a procedure code was performed more than once per day. If the same procedure code is performed more than once and there are anatomical modifiers to indicate that the services were performed in different sites, then those should be used. If there is no anatomical modifier to indicate that the procedure was performed more than once on the same day, then modifier 76 would be necessary to show that the procedure is a repeat.

- If a patient gets Lumbar and Cervical Traction on the same day what modifier would we use? 76?
  
  A: Yes, modifier 76 would be appropriate on the subsequent line items that have the same procedure code. The first line item would not contain a modifier 76.

- When billing for Discograms CPT 62290 and 72285, I have been using Modifier 59 for additional levels Example: C1-2, C3-4 etc. Are you saying I should be using Mod 76 instead now?
  
  A: Modifier 59 should not be used to indicate that a procedure code was performed more than once per day. If the same procedure code is performed more than once and there are anatomical modifiers to indicate that the services were performed in different sites, then those should be used. If there is no anatomical modifier to indicate that the procedure was performed more than once on the same day, then modifier 76 would be necessary to show that the procedure is a repeat.
When our office does injections 20605 for the right wrist and right elbow on the same day- for the meds (J codes) we would add a 59 modifier. What would be the appropriate modifiers to use now on all the codes? Also, on lesions, we may have one on the hand and also the forearm, which are different locations we would use the same procedure code and add a 59 modifier to the second procedure code. Effective 7-1-13 would we bill the same and add a 76 modifier?

Primary care is 22612 and add on is 22614 x 4 levels - we understood that add-on codes do not require a modifier - are we now needing to use 76?

A: Modifier 59 should not be used to indicate that a procedure code was performed more than once per day. If the same procedure code is performed more than once and there are anatomical modifiers to indicate that the services were performed in different sites, then those should be used. If there is no anatomical modifier to indicate that the procedure was performed more than once on the same day, then modifier 76 would be necessary to show that the procedure is a repeat.

Oncology

We bill for medical oncology, and use multiple dose forms of chemotherapy drugs to reach the patient’s necessary dose. This involves multiple NDC’s that we must report separately. The CMS web page “Modifiers for Medicare Billing” does not have a section for drugs and biologicals. The webinar today listed the CPT code groups that the modifier 76 would be appropriate for, and the J codes for drugs were not listed in the presentation. Is the 76 modifier appropriate?

Please see the following scenario:

J9035 (1ST NDC# REPORTED) 40 UNITS
J9035-76 (2ND NDC# REPORTED) 20 UNITS

THANK YOU FOR YOUR HELP.

A: Modifier 76 would be the appropriate modifier to indicate that the same procedure was performed more than one time per day.
• What about a BID? Sometimes a patient receives a treatment in the morning, and then at least six hours later comes back for another treatment, should we use the 59?
  A: Modifier 76 would be the appropriate modifier to indicate that the same procedure was performed more than one time per day.

• We are an oncology practice and administer chemotherapy in our office. We use infusion codes and append modifier 59 if we have more than 1 of same infusion on same day, is this correct i.e. 96367 and 96367-59?
  A: Modifier 76 would be the appropriate modifier to indicate that the same procedure was performed more than one time per day.

• Drugs and biological are not included in the CPT code ranges from the modifier 76, when separate NDC’s are used, is Modifier 76 appropriate for that scenario? Drugs and biological are not listed on the CMS modifiers for medical billing webpage.
  A: Modifier 76 would be the appropriate modifier to indicate that the same procedure was performed more than one time per day.

**Pain Management**

• Many pain management injections/surgery CPT codes are appropriately billed with modifier 59. They are the same CPT but are linked to different diagnoses - will these codes also auto deny? (i.e. 20610 shoulder diagnosis and 20610-59 with hip diagnosis).
  A: Modifier 59 should not be used to indicate that a procedure code was performed more than once per day. If the same procedure code is performed more than once and there are anatomical modifiers to indicate that the services were performed in different sites, then those should be used. If there is no anatomical modifier to indicate that the procedure was performed
more than once on the same day, then modifier 76 would be necessary to show that the procedure is a repeat.

**Physical Therapy**

- If we bill 3 units of therapeutic exercise (97110), 1 unit therapeutic activity (97530), and 1 unit of a modality (G0283) we currently have to use modifier 59 with the 97530 and G0283 for them to be processed with the 97110. Is this changing with the new rule? Also do we now need to use modifier 76 when billing the 3 units of 97110 on one line together?

  A: Please refer to NCCI edits for the proper billing of modifier 59 on any procedures. Our instructions in no way indicated that services could no longer be filed as multiple units on the same line if that is how the provider has been submitting the claim. The education we performed was strictly for “duplicate” services, meaning that if you file the exact same procedure code on the same date of service with modifier 59, it will be denied as a duplicate because modifier 59 is not appropriately filed as a repeat modifier.

**Radiology**

- If we are billing for x-rays on RT and LT feet, do we need to use the 76 modifier or can we just use the anatomical modifier or do bilateral mod 50?

  A: For the proper use of modifier 50, please refer to the fee schedule section of our website. The national relative value file indicates which services can be submitted with a modifier 50. If there is a 1 in the bilateral procedure column, then modifier 50 can be utilized.

  If filing modifier RT and LT, you do not need to also use modifier 76. The RT and LT will identify the services in our system as two different anatomical sites.
Urinary

- The conference only told us how to bill when using same CPT codes on same DOS, replacing the 59 modifier with the 76 modifier, but did not tell us what to expect as a response or how to support the duplicated CPT code when using the 76 modifier, i.e. right urethral ESWL, 50590-RT DX 592.1, with right renal ESWL, 50590-RT DX 592.0. This is the same procedure on the same side, but the locations are different. Does this mean your edit system will also be looking at the diagnosis and, therefore, will recognize these as being in different locations? For years, Medicare has always indicated use of 76 modifier would only trigger denial.

  A: The revised duplicate logic and the previous duplicate logic have never looked at diagnosis codes to make a determination on payment. If the same procedure is performed more than one time per day, the first line item would be filed without modifier 76 and the subsequent line items with the same procedure code would include modifier 76.

- If ESWL, 50590, and lithotripsy, 52353, are done on the same renal or urethral stone due to the fact one method only partially fragmented the stone, is this allowed with -59 modifier?

  A: The rules for Modifier 59 usage have not changed. The provider should check NCCI edits prior to claims submission to verify if appending any modifier to their claim is appropriate/allowed.

- We do a lot of straight caths several times a day on patients with post-op urinary retention. Can I use 51701 however many times we do it with modifier 76?

  A: Yes, modifier 76 would be appropriate on the subsequent line items that have the same procedure code. The first line item would not contain a modifier 76.
Other Scenarios

- We are a unique company, sometimes our claims are more than 99,999 units. In the past we split the claim and use 59 Modifier. The J-code (example:J7192) and diagnosis code (example:286.0) are the same. What would we do now? And do we put them on same claim or separate claims?
  
  A: The first line item would be filed without modifier 76 and any subsequent lines for the same procedure should include modifier 76. If at all possible, the services should all be filed on one claim form.

- I work at a hospital and I frequently use the 59 modifier for repeat IV pushes in ER, foley insertion vs. an EKG or surgical procedure and other type edits. Will there be a use of the 59 for the hospital? If not, where might I look for clarification of the edits that occur particularly on ER claims? Much of the information discussed today was very helpful to understand the 59 modifier. However, there are times, particularly in the ER, where 59 is the only option.
  
  A: The rules for Modifier 59 usage have not changed. The provider should check NCCI edits prior to claims submission to verify if appending any modifier to their claim is appropriate/allowed. The modifier 59 is not appropriately filed when it is used to indicate that a single procedure code was performed more than once per day (repeat service). Modifier 76 or an anatomical modifier is the appropriate modifier to indicate that the same procedure code was repeated more than once per day.

- How do you bill when you have 200,000 units and $300,000? We were told to enter modifier 59 on the claim. What would we do now to avoid duplicate?
  
  A: The first line item would be filed without modifier 76 and any subsequent lines for the same procedure should include modifier 76. If at all possible, the services should all be filed on one claim form.
• When we currently bill J2357 with 96372 on three separate lines (because it is 3 injections) is 76 the only modifier needed.

  A: Cahaba GBA cannot advise on whether other modifiers would be needed or appropriate with the information provided. We can only advise that modifier 59 should not be used as a repeat modifier on the same procedure code being filed more than once per day. If the same procedure code is being filed more than once per day, then the services would need to be submitted with anatomical modifiers or modifier 76 or 91 as appropriate.

• We currently use the modifier 59 for our second session of hyperbaric oxygen therapy CPT 99183. We would bill 99183 for the first session and then 99183-59 for the second session. Would we continue to bill this way? If not what would be the correct way to bill to capture the second session?

  A: Modifier 59 should not be used to indicate that a procedure code was performed more than once per day. If the same procedure code is performed more than once and there are anatomical modifiers to indicate that the services were performed in different sites, then those should be used. If there is no anatomical modifier to indicate that the procedure was performed more than once on the same day, then modifier 76 would be necessary to show that the procedure is a repeat.

• We bill out several immunizations and shot administrations with them. When we have 3 or more shots and we bill the 90471 for the first and 90472 for all shots following, do you suggest we use the 76 to separate theses or would the 59 still be what we use? Currently we use the 59 on number 3 and all 90472’s thereafter.

  A: Modifier 59 should not be used to indicate that a procedure code was performed more than once per day. If the same procedure code is performed more than once and there are anatomical modifiers to indicate that the services were performed in different sites, then those should be used. If there is no anatomical modifier to indicate that the procedure was performed more than once on the same day, then modifier 76 would be necessary to show that the procedure is a repeat.
When billing an E&M visit with a modifier 25 and an administration of injections with modifier 59, both administered on the same date of service will this pass the new edits for the modifier 59 that are to take place on July 1, 2013?

A: The edit logic we are referring to is strictly related to exact duplicate services. Since you are referring to different procedure codes, then the exact duplicate logic does not apply to your situation. We have been advising what will happen if the same procedure is performed more than once per day and modifier 59 is used to indicate that repeat services were performed.

Which modifier would you use for the Flu Test A & B 87804?

A: Modifier 91 is utilized for laboratory procedures that are performed more than once per day.

In regards to Injection administration with distinct different diagnosis and two shots are given is it 96372 unit 2 or 96372 and 96372-76?

A: Our instructions regarding modifier 59 and duplicate claims processing did not change the way providers have previously been filing when multiple units of service are involved on one line item. If you have always filed with multiple units of service and have had no issues with processing, then you will continue to submit claims as you normally do.

If billing for drugs with 2 different NDC codes would we bill the drug on 2 separate lines with same HCPCS code but different NDC codes? What modifier needs to be used to get through the duplicate edit?

A: Modifier 76 would be the appropriate modifier to indicate that the same procedure was performed more than one time per day.