Mod	Modifier Description, Definition, Explanation, and Tips
TA	**Left foot, great toe** **Definition:** Append modifier TA to identify that the provider performs a procedure on the great toe of the left foot. **Explanation:** This modifier identifies services that the provider performs on the great toe of a patient's left foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** The reimbursement for this code depends on carrier judgment. For Mitchell osteotomy in the left first metatarsal use 28296, Correction, hallux valgus or bunion, with or without sesamoidectomy; with metatarsal osteotomy, e.g., Mitchell, Chevron, or concentric type procedures and append modifier TA. Use code 28750 Arthrodesis, great toe; metatarsophalangeal joint for Arthrodesis or fusion of the joint connecting the great toe to the foot. For arthrodesis of the left foot with great toe therefore use 28750 TA. Use code 28755 Arthrodesis, great toe; interphalangeal joint for Arthrodesis or fusion of the joint connecting the small bones within the great toe to the foot. For arthrodesis of the small joints within the left great toe therefore use 28755 TA. For nail debridement, do not add toe modifiers since up to five nails are included in the nail debridement code 11720, Debridement of nails by any method; one to five. You could include the T modifiers to be more specific to the carrier. For avulsion of ingrown toe nails, use the CPT® code 11730, Avulsion of nail plate, partial or complete, simple; single. Append the appropriate toe modifier depending on which toe nail the provider treats. If the provider treats two or more nails, report each with appropriate T modifier separately. For biopsy of a nail unit use CPT® code 11755, Biopsy of nail unit, and append appropriate T modifier. For example for biopsy of left great toe, report 11755 TA. A patient presents with five ingrown toenails. The provider completes simple avulsion on both sides of left foot, great toe and right foot, great toe, and one side of left foot, second digit. Report 11730 TA, left foot, great toe; 11732 T5 59, Avulsion of nail plate, partial or complete, simple; each additional nail plate, right foot, great toe; 11732 T1 59, left foot, second digit. 11732 is used for each additional nail plate after the first 11730. Use amputation codes 28810, Amputation, metatarsal, with toe, single for amputation of the metatarsal ray along with the attached toe; or code 28825, Amputation, toe; interphalangeal joint, when the provider removes a toe from its interphalangeal joint. Append the T modifier according to the toe the provider removes.
TB	**Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes** **Definition:** Append modifier TB for informational purposes to a code for a drug or biological (a drug derived from a living organism using biotechnology) purchased at a discount as determined by the 340b Drug Pricing Program. **Explanation:** Modifier TB indicates that a drug was purchased at a discount as determined under the 340B Drug Pricing Program. This modifier is for informational purposes, meaning that although the drug was purchased at a discount, other conditions stipulated by the 340B Drug Pricing Program may not apply. Biological refers to a drug derived from human, animal, or microorganism components using biotechnology; examples include cells, genes, tissues, recombinant proteins, vaccines, allergens, and blood and blood components. **Tips:** The price of drugs covered by the Drug Pricing Program is calculated based on a formula contained in section 340B(a)(2) of the Public Health Service Act. Participating providers in this program who may purchase drugs at these significantly lower prices are registered with DHHS/HRSA's Office of Pharmacy Affairs (www.hrsa.gov/opa).
TC	**Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable X-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable X-ray suppliers will then be used to build customary and prevailing profiles** **Definition:** A provider appends modifier TC to bill for the technical component of a test only. **Explanation:** Append modifier TC to report the technical component of a procedure that has both a technical and professional component, the payment for which consists of the practice and the malpractice expenses. The provider commonly appends this modifier to procedures such as injection administration, laboratory, radiology, surgery, and radiation therapy. **Tips:** Append modifier TC if the procedure reads as 1, in the PC or TC indicator on the Medicare physician fee schedule database, or MPFSDB. As modifier TC is a payment modifier, report this modifier as the first modifier.