Medicare Part B Informational Only Modifiers Cheat Sheet

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Introduction

Modifiers:

For Medicare purposes, modifiers are two-digit codes that may consist of alpha and/or numeric characters, which may be appended to procedure codes and/or HCPCS codes, to provide additional information needed to process a claim. This includes both HCPCS Level 1 (CPT) and HCPCS Level II codes. Modifiers answer the questions such as, which one, how many, what kind, and when?

Definition

- A two-digit code appended to procedure codes
- May affect reimbursement
- May be informational only
- Updated annually

What is the purpose of a Modifier?

Used on a Medicare Claim to provide additional information for the code that is being billed and, if approved, may determine the payment for the code.

Payment Modifier vs Informational Modifier

The CPT coding system includes 2-digit modifier codes used to report that a service or procedure has been altered or modified by some specific circumstance without altering or modifying the basic definition for the CPT code. Proper use speeds up claim processing, while improper use can result in claim delays, rejections, or denials.

Informational Modifiers are Used for "informational" purposes only, and do not affect reimbursement, while **Pricing or Payment Modifiers**, always affect reimbursement. Understanding which modifiers affect reimbursement and which ones do not is critical to properly submit a claim when more than one modifier is needed to describe a single CPT code.

The Multi-Carrier System (MCS), used for claims processing, requires placement of pricing/payment modifiers in the first modifier position. Some pricing/payment modifiers are not limited to the first position. In such cases, if there is another pricing modifier submitted that is required to be in the first modifier field, these modifiers should be in the second, third or fourth modifier position.

When more than four modifiers apply, enter modifier 99 in the first modifier field. In the narrative field (item 19 on the claim form), list all modifiers in the correct ranking order, making sure to identify which detail line or procedure code to which the modifiers apply

Informational Modifiers

Informational Modifiers (cont)

GW Service not related to the hospice patient's terminal condition

GY Statutorily excluded service - If the service provided is statutorily excluded from the Medicare Program, the claim will deny whether or not the modifier is present on the claim

GZ The provider or supplier expects a medical necessity denial; however, did not provide an Advance Beneficiary Notice of Noncoverage (ABN) to the patient

Q5 Service furnished by a substitute physician under a reciprocal billing arrangement

Q6 Service furnished by a locum tenens physician

22 Increased Procedural Service requiring work substantially greater than typically required

24 Unrelated evaluation and management (E/M) service by the same physician* during a postoperative period

25 Significant, separately identifiable evaluation and management (E/M) service by the same physician* on the day of a procedure

27 Multiple Outpatient Hospital E/M Encounters on the Same Day (Not required by CMS and not to be used by physicians for reporting of multiple E/M services)

52 Reduced Service reports a partially reduced or eliminated service or procedure

57 Indicates an Evaluation and Management (E/M) service resulted in the initial decision to perform surgery either the day before a major surgery (90-day global) or the day of a major surgery

58 Indicates a staged or related procedure or service by the same physician* during the postoperative period

59 Distinct Procedural Service identifies procedures/services not normally reported together, but appropriately billable under the circumstances

63 Procedure Performed on Infants less than 4 kg

66 If a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66"

74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure after administration of anesthesia

76 Repeat Procedure by the Same Physician; use when it is necessary to report repeat procedures performed on the same day

77 Repeat Procedure by another physician

79 Unrelated procedure by the same physician during the postoperative period

90 Reference (Outside) Laboratory

99 Multiple Modifiers are required on one line of service

Modifier 99 has specific instructions on its own separate fact sheet.

AQ Services provided in a Health Professional Shortage Area (HPSA)
CB Services ordered by a dialysis facility physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable
CR Emergency health care needs of beneficiaries and providers affected by Hurricane Katrina and any future disasters
GA The provider or supplier has provided an Advance Beneficiary Notice of Noncoverage (ABN) to the patient and has a signed copy on file
GN Services delivered under an outpatient speech-language pathology plan of care
GO Services delivered under an outpatient occupational therapy plan of care
GP Services delivered under an outpatient physical therapy plan of care
GV Attending physician not employed or paid under agreement by the patient's hospice provider