



Informational Only Modifiers Fact Sheet

The following modifiers are ***Informational Only*** and should be placed after all pricing modifiers. 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.
- 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.



- QW CLIA waived test
- 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 Date (This should not be submitted)
- 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 post-operative period
- 90 Reference (Outside) Laboratory
- 99 Multiple Modifiers are required on one line of service

***Same physician** – Medicare regulation states: *“Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.”* The same physician concept also applies when the exact same physician performs services.