

MODIFIER POSITION FACT SHEET

Modifier Submission

The Multi-Carrier System (MCS) used for claims processing requires placement of pricing modifiers in the first modifier position to process claims correctly. Place the modifiers listed below (except modifiers with an *) to the right of the procedure code in Item 24D. Processing delays can occur for claims submitted without the pricing modifier in the first modifier position.

| AA | Anesthesia service personally performed by anesthesiologist |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| AD | Medical supervision by a physician; more than four concurrent anesthesia procedures |
| AS* | Assistant at surgery services provided by a Physician Assistant (PA) or Nurse Practitioner (NP) |
| KD** | Drug administered through a DME infusion pump |
| QK | Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals |
| QW | CLIA waived tests |
| ΩX | Certified Registered Nurse Anesthetist (CRNA) service: with medical direction by a physician |
| QY | Medical direction of one CRNA by an anesthesiologist |
| QZ | CRNA service: without medical direction by a physician |
| TC | Technical component |
| 26 | Professional component |
| 50* | Bilateral Procedure performed at the same session on an anatomical site |
| 53 | Discontinued procedure (only when appended to procedure codes 45378, G0105, G0121) |
| 54* | The surgeon is billing the surgical care only |
| 55* | Indicate a physician, other than the surgeon, is billing for part of the outpatient postoperative care Or: Used by the surgeon when providing only a portion of the post-discharge post-operative care |
| 62* | Two surgeons (each in a different specialty) are required to perform a specific procedure |
| 66* | Team surgeons |
| 73* | Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) procedure prior to the administration of anesthesia |
| 78* | Return to an operating room for a related procedure during the postoperative period |
| 80* | Assistant at surgery service is provided by a medical doctor (MD) |
| 82* | Assistant at surgery service provided by a MD when there is no qualified resident available |

^{*} These payment modifiers are not limited to the first position. (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.)

(continued on next page)

^{**} If multiple pricing or payment modifiers are submitted, the KD modifier should be placed in the first modifier position field.



Processing delays can occur for claims submitted without the pricing modifier in the first modifier position. Informational only.

| AQ | Services provided in a Health Professional Shortage Area (HPSA) |
|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| СВ | 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 |
| G0 | 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 |
| 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 |
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^{*} 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.

References: Pricing or Payment Modifier and Informational Only Modifier Fact Sheets, Wisconsin Physician Services (WPS), www.wpsmedicare.com

QUESTIONS?