Codify
BY AAPC

Modifier Coding Alert

Reader Question: Modifier 99 May Simplify Reporting Codes

Question: My health professional shortage area physician performs an E/M service for another physician in the practice who is suddenly taken ill. We have a signed advance beneficiary notice (ABN) on file for the patient. The patient received chemotherapy earlier that day by the same physician. How do I report the multiple modifiers that I need?

Wisconsin Subscriber

Answer: You will not typically report multiple modifiers on one code so you may not be familiar with modifier 99 (Multiple modifiers). But on occasion, you may need two or more modifiers to fully portray a service and there may not be enough room in your online application or paper form. That's when you may turn to 99.

In this case, report the appropriate E/M service (99211-99215, Office or other outpatient visit for the evaluation and management of an established patient, ...) with Q6 (Service furnished by a locum tenens physician) attached. You also need to attach modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) because the patient received chemotherapy earlier that day by the same physician.

Additionally, you need modifier AQ (Physician providing a service in an unlisted health professional shortage area [HPSA]) because the physician is providing the service in a HPSA. Plus, because your office has an ABN a signed by the patient on file, you need to include GA (Waiver of liability statement issued as required by payer policy, individual case).

You may put 99 in box 24D on the same line as the service and list the other four modifiers in box 19. If you had fewer than four modifiers, modifier 99 wouldn't be necessary.

Tip: "In the rare instance where a modifier 99 might be needed we should ask our top payers how they want multiple modifiers to be illustrated," suggests **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, director of coding operations at Allegheny Health Network in Pittsburgh, Pa. "It may only be used by a few select payers when they want the claim to go into a queue for further review."

Make a call: Ask your payers how they want you to report the modifiers because there are differences of opinions on how to report multiples.

Some of the different opinions you'll get are:

- List 99 first and follow it with all other applicable modifiers in box 24D
- Put 99 in modifier box 24D and list all of the other modifiers in box 19 and separate by commas
- Some payers don't require modifier 99 when more than one modifier applies to a procedure
- List the modifiers that directly affect reimbursement first and follow them with the informational modifiers.

CMS opinion: You can expect a claim denial from CMS if there are any other modifiers on a line of service with 99.

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