



Modifier 99 Fact Sheet

Definition:

- Multiple Modifiers are required on one line of service.

Appropriate Usage:

- Reportable on all procedure codes
- Report modifier 99 in the first modifier position on the line of service
 - list all other modifiers in item 19 or the equivalent electronic data field.
- If the claim has more than one detail line, indicate the detail line number in Item 19 or the equivalent electronic data field.

Inappropriate Usage:

- Reporting three different modifiers in the first three modifier fields and then 99 in the fourth.
- Reporting less than five modifiers for one line of service

Example:

Bill only Modifier 99 on the line, place all other modifiers in item 19 or its electronic equivalent.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|----|----|-------------|--|--|---------|--|-------|----|---------------------|--|---|--------|--|--|-------------------|------------|----------------------|--|---------------|--|------------------|--|------------------------|--|--------------|--|-----------------------------|--|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | 17a. | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 17b. NPI | | FROM MM DD YY | | | | TO MM DD YY | | | | | | | | | | | | | |
| 1. XX XX XX XX XX XX XX (List modifiers and detail line they apply to here) | | | | | | | | | | | | 20. OUTSIDE LAB? \$ CHARGES | | | | | | | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | | | | | | | <input type="checkbox"/> YES | | | | | | | | | | | | | | | | | |
| 1. 5963 | | | | | | | | | | | | 22. MEDICAL NECESSITY | | | | ORIGINAL REF. NO. | | | | | | | | | | | | | |
| 2. _____ | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE | | | | | | | | | | B. PLACE OF SERVICE | | C. EMG | | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | | E. DIAGNOSIS POINTER | | F. \$ CHARGES | | G. DAYS OR UNITS | | H. EP80T (Family Plan) | | I. ID. QUAL. | | J. RENDERING PROVIDER ID. # | |
| From MM DD YY | | | To MM DD YY | | | SERVICE | | | | CPT/HCPCS | | | | MODIFIER | | | | | | | | | | | | | | | |
| 1 | 04 | 02 | 06 | | | 11 | | 21975 | 99 | | | 1 | 175.00 | 001 | | NPI | 1234567890 | UPPLIER INFORMATION | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | NPI | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | NPI | | | | | | | | | | | | | |

The only modifier on the line should be Modifier 99. The claim will not be able to be processed.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|----|----|-------------|--|--|---------|--|-------|-------------|---------------------|--|---|--------|--|--|-------------------|------------|----------------------|--|---------------|--|------------------|--|------------------------|--|--------------|--|-----------------------------|--|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | 17a. | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | | | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 17b. NPI | | FROM MM DD YY | | | | TO MM DD YY | | | | | | | | | | | | | |
| 1. XX XX XX XX XX XX XX (List modifiers and detail line they apply to here) | | | | | | | | | | | | 20. OUTSIDE LAB? \$ CHARGES | | | | | | | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | | | | | | | <input type="checkbox"/> YES | | | | | | | | | | | | | | | | | |
| 1. 5963 | | | | | | | | | | | | 22. MEDICAL NECESSITY | | | | ORIGINAL REF. NO. | | | | | | | | | | | | | |
| 2. _____ | | | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE | | | | | | | | | | B. PLACE OF SERVICE | | C. EMG | | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | | E. DIAGNOSIS POINTER | | F. \$ CHARGES | | G. DAYS OR UNITS | | H. EP80T (Family Plan) | | I. ID. QUAL. | | J. RENDERING PROVIDER ID. # | |
| From MM DD YY | | | To MM DD YY | | | SERVICE | | | | CPT/HCPCS | | | | MODIFIER | | | | | | | | | | | | | | | |
| 1 | 04 | 02 | 06 | | | 11 | | 21975 | 59 76 72 99 | | | 1 | 175.00 | 001 | | NPI | 0123456789 | UPPLIER INFORMATION | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | NPI | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | NPI | | | | | | | | | | | | | |