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Modifiers Recognized by Ohio Medicaid Fee-For-Service (FFS)

Modifiers are two-character codes used along with a service or supply procedure code to provide additional information about the service or supply rendered. Care must be taken when reporting modifiers with procedure codes because using a modifier inappropriately can result in the denial of payment or an incorrect payment for a service or supply. The Ohio Department of Medicaid (ODM) accepts many, but not all, modifiers recognized by the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), and the American Society of Anesthesiologists (ASA).

ODM also recognizes Medicaid state specific HCPCS modifiers beginning with the letter *U*. These state-specific "U-modifiers" can be tailored to an individual state's Medicaid policy when no other modifier adequately represents the policy purpose. The state determines how each U modifier is to be used and the same U-modifier can take on different meanings when it is used with different service or supply codes.

Medicaid rules governing services are generally grouped within the Ohio Administrative Code (OAC) by the type of provider or the nature of the service. The following list shows which modifiers ODM recognizes on *fee-for-service (FFS) claims* for various services or supplies. Not every modifier can be used with every service or supply code in a group. Using an inappropriate modifier for a service or supply or a modifier ODM does not recognize will cause a line-item denial.

Please note that this FFS modifier list is used for FFS claims submitted to ODM. The Medicaid managed care entities (MCEs), which includes the OhioRISE plan, the managed care organizations (MCOs) and MyCare Ohio Plans (MCOPs), may have different claim submission requirements.

General Provisions, OAC Chapter 5160-1

GT	Identifies a service as telehealth
Q6	Substitute practitioner (locum tenens)
SE	Drug acquired through the 340B drug pricing program
U1	Used to identify the patient location of “home” when a telehealth service was delivered
U2	Used to identify the patient location of “school” when a telehealth service was delivered
U3	Used to identify the patient location of “inpatient hospital” when a telehealth service was delivered
U4	Used to identify the patient location of “outpatient hospital” when a telehealth service was delivered
U5	Used to identify the patient location of “nursing facility” when a telehealth service was delivered
U6	Used to identify the patient location of “Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)” when a telehealth service was delivered

Outpatient Hospital Services, OAC rule 5160-2 for Dates of Service Beginning 08/01/2017

Note: All valid modifiers are accepted on outpatient hospital claims. However, only the following modifiers affect outpatient hospital claim payment.

25	Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional during a postoperative period
27	Multiple outpatient hospital E/M encounters on the same date
50	Bilateral procedure
52	Reduced services
59	Distinct procedural service

73	Outpatient hospital/ambulatory surgery center (ASC) procedure discontinued prior to the administration of anesthesia
HE	Outpatient behavioral health service [Modifier HE is reported in conjunction with other appropriate modifiers. See "Applicable Modifiers for OPHBH Services Provided by Outoatient Hospitals" at http://medicaid.ohio.gov (website) > Providers (tab) > Fee Schedule and Rates (drop-down tab item) > (agreement confirmation) > Outpatient Hospital Behavioral Health Services (drop-down list) > Modifiers for Outpatient Behavioral Health (list item).]
JW	Drug amount discarded/not administered to any patient
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient
SE	Drug acquired through the 340B drug pricing program
UB	Invoke independently billed payment logic

Outpatient Hospital Services, OAC rule 5160-2-21 with Appendix A Dates of Service Through 07/31/2017

22	Unusual procedural service
73	Surgery procedure discontinued before anesthesia administration
74	Surgery procedure discontinued after anesthesia administration
TH	Obstetrical service, prenatal or post-partum
U1	Pediatric patient, chronically or severely ill
U2	Adult patient, chronically ill
UB	Age less than 21 or greater than 59

Professional Medical Services, OAC Chapter 5160-4

24	Unrelated evaluation and management service by the same physician or other qualified health care professional during the postoperative period
25	Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of the procedure or other service
26	Professional component of a procedure that has both a technical and a professional component

33	Preventative services [Modifier 33 is used to indicate the submission of the electronic pregnancy risk assessment when billed with procedure H1000]
50	Bilateral procedure
51	Multiple procedure
58	Staged or related procedure or service by same physician during the postoperative period
59	Distinct procedural service [Modifier 59 is used to indicate the second or subsequent delivery of a multiple birth.]
62	Co-surgery
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
79	Unrelated procedure by same physician or other qualified health care professional during the postoperative period
80	Assistant-at-surgery service [physician only]
AA	Anesthesia service personally furnished by an anesthesiologist

AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
AS	Assistant-at-surgery service [physician assistant, certified nurse practitioner, or clinical nurse specialist]
EP	Service provided under Healthchek (EPSDT)
E1	Eyelid, upper left
E2	Eyelid, lower left
E3	Eyelid, upper left
E4	Eyelid, lower right
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
FS	Split (or shared) evaluation and management visit
FT	Unrelated evaluation and management (E/M) service within the postoperative period or on the same day as a procedure or another E/M visit
GC	Service performed in part by a resident under the direction of a teaching physician
GE	Service performed by a resident without the presence of a teaching physician under the primary care exception rule
GV	Attending physician not employed or paid under arrangement by the patient's hospice provider
GW	Service not related to the hospice patient's terminal condition
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LT	Left side [used to identify procedures performed on the left side of the body]

QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist
QW	CLIA waived version of a high- or moderate-complexity laboratory procedure
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA without medical direction by a physician
RC	Right coronary artery
RT	Right side [used to identify procedures performed on the right side of the body]
SA	Certified nurse practitioner
SB	Certified nurse-midwife
SK	Member of a high risk population (use only with codes for immunization)
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TC	Technical component of a procedure [performed in a non-hospital setting]
TD	Visit conducted by a registered nurse (RN)
TH	Obstetrical service, prenatal or post-partum
UB	Transport of a critically ill or injured patient over 24 months of age
UC	Clinical nurse specialist
UD	Physician assistant
XE	Service that is distinct because it occurred during a separate encounter
XP	Service that is distinct because it was performed by a different practitioner
XS	Service that is distinct because it was performed on a separate organ/structure
XU	Service that is distinct because it does not overlap usual components of the main service

Eye Care Services, OAC Chapter 5160-6

52	Spectacle fitting service for less than a complete pair of spectacles
UB	Comprehensive ophthalmologic service for an individual younger than 21 or older than 59, allowed once per year [applicable only to CPT procedure codes 92002 and 92014]

Other Licensed Professional Services, OAC Chapter 5160-8

AE	Registered dietitian
AH	Clinical psychologist
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
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral degree level

Durable Medical Equipment, Prostheses, Orthoses, and Supplies, OAC Chapter 5160-10

BO	Nutrition administered orally without a tube
LT	Left side [used to identify procedures performed on the left side of the body]
QE	Prescribed oxygen < 1 LPM
QF	Prescribed oxygen > 4 LPM, portable
QG	Prescribed oxygen > 4 LPM
RB	Repair of a DMEPOS item or replacement of a part during repair
RR	Rental
RT	Right side [used to identify procedures performed on the right side of the body]
U1	DME item (oxygen concentrator) used in a personal residence
U1, U2, U3, etc.	Specific model or type of DMEPOS item (e.g., a customized tracheostomy tube)
UE	Used durable medical equipment

Independent Laboratory, Portable X-ray, or Independent Diagnostic Testing Facility (IDTF) Services, OAC Chapter 5160-11

26	Professional component of a procedure that has both a technical and a professional component
26	Clinical pathology interpretation of a clinical diagnostic procedure for which separate payment is allowed
90	Reference (outside) laboratory
91	Repeat laboratory procedure or service performed on the same day
QW	CLIA waived laboratory procedure or CLIA waived version of a high-or moderate-complexity laboratory procedure
TC	Technical component of a procedure that has both a technical and a professional component

Ohio Home Care Program, Home Health Services, OAC Chapter 5160-12

HQ	Group visit
U1	Infusion therapy [reported with procedure code G0299]
U2	Second visit made on the same date for the same type of service
U3	Each additional visit beyond the second made on the same date for the same type of service
U5	Service provided under Healthchek (EPSDT)
U7	Time beyond 14 hours per week of home health nursing and home health aide services

Ohio Home Care Program, Private Duty Nursing Services, OAC Chapter 5160-12

HQ	Group visit
TD	Visit conducted by a registered nurse (RN) for the provision of a PDN service [reported with procedure code T1000]
TE	Visit conducted by a licensed practical nurse (LPN) for the provision of a PDN service [reported with procedure code T1000]
TU	PDN visit [reported with procedure code T1000] conducted by a non-agency RN or LPN that is claimed in its entirety as overtime
U1	Infusion therapy [reported with procedure code T1000]
U2	Second visit made on the same date for the same type of service
U3	Each additional visit beyond the second made on the same date for the same type of service
U4	Visit lasting more than 12 hours but not more than 16 hours
U5	Service provided under Healthchek (EPSDT)
UA	PDN visit [reported with procedure code T1000] conducted by a non-agency RN or LPN that is claimed in part as overtime

Ohio Home Care Program, RN Assessment and RN Consultation Services, OAC Chapter 5160-12

U9	RN consultation service [reported with procedure code T1001]

Transportation, OAC Chapter 5160-15

	More than 100 different two-character modifiers may be used with procedure codes representing ambulance or wheelchair van services. Most of these modifiers identify the origin or destination of a trip, some indicate circumstances that affect payment, and some convey other information. Rarely used or unlikely combinations of procedure code and modifier may require human intervention in the processing of the claim. Because of the multiplicity of possibilities, specific modifiers are not listed here. The appendix to OAC rule 5160-15-28 gives a succinct summary. [http://codes.ohio.gov/oac/5160-15-28, 'Click to view Appendix']

Ambulatory Surgery Center Services, OAC rule 5160-22-01

Note: All valid modifiers are accepted on ambulatory surgery center (ASC) facility claims. However, only the following modifiers affect ASC facility claim payment.

25	Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional during a postoperative period
50	Bilateral procedure
52	Reduced services
59	Distinct procedural service
73	Outpatient hospital/ambulatory surgery center (ASC) procedure discontinued prior to the administration of anesthesia
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

ODMHAS-Certified Community Mental Health and Substance Use Disorder Agency Services, OAC Chapter 5160-27, OAC Rule 5160-8-05

25	Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of the procedure or other service
59	Distinct procedural service
AF	Physician delivering SUD group counseling
AM	Physician, team member (ACT)
GT	Secured video-conferencing [See code charts and BH Provider Manual for allowable services.]
HD	Buprenorphine, generic, per 1 mg
HF	Opioid treatment program (OTP) daily administration
HG	OTP four-week administration (22-28 days)
HI	Cognitive Impairment (SUD residential ASAM level 3.3)
HK	Licensed practitioner providing TBS group hourly/per diem (day treatment) or SUD group counseling
HM	High school or associate's level degree
HN	Bachelor's level degree
HO	Master's level degree
HQ	Group service

KX	Crisis [used with T1002, H2017 (PSR only, not LPN nursing service), H2019, H0004, and 90832]

QW	CLIA waived laboratory procedure or CLIA waived version of a high-or moderate-complexity laboratory procedure
SA	Physician's assistant or clinical nurse specialist, team member (ACT)
TD	Additional license, registered nurse (RN)
TE	Additional license, licensed practical nurse (LPN)
TG	Complex/high-tech level of care
TS	OTP three-week administration (15-21 days)
TV	OTP one-week administration (2-7 days)
U1	Psychology assistant, psychology assistant intern, psychology assistant trainee
U2	Licensed professional counselor
U3	Licensed chemical dependency counselor II
U3	Licensed chemical dependency counselor III
U4	Licensed social worker (LSW)
U5	Licensed marriage and family therapist (LMFT)
U6	Chemical dependency counselor assistant
U7	Counselor trainee
U8	Social worker assistant
U9	Social worker trainee
UA	Marriage and family therapist trainee
UB	Additional license, licensed independent clinical dependency counselor (LICDC) or OTP two-week administration (8-14 days)
UC	Certified nurse practitioner, team member (ACT)
UF	Additional license, licensed independent social worker (LISW)
UG	Additional license, licensed independent marriage and family therapist (LIMFT)
UH	Additional license, licensed professional clinical counselor (LPCC)
UK	QMHS with 3 years' experience
XE	Service that is distinct because it occurred during a separate encounter
XP	Service that is distinct because it was performed by a different practitioner
XS	Service that is distinct because it was performed on a separate organ/structure
XU	Service that is distinct because it does not overlap usual components of the main service

FQHC, RHC Services, OAC Chapter 5160-28

The following modifiers are reported with procedure code T1015 to identify the category of FQHC/RHC service. The specific services provided are then reported by procedure code on separate details.

U1	FQHC medical services visit / RHC medical services visit / RHC mental health services visit
U2	FQHC dental services visit
U3	FQHC mental health services visit [Services rendered by a psychiatrist—i.e., a physician—are reported as medical services with T1015-U1.]
U4	FQHC physical therapy services or occupational therapy services visit
U5	FQHC speech pathology services or audiology services visit
U6	FQHC podiatry services visit
U7	FQHC vision services visit
U8	FQHC chiropractic services visit
U9	FQHC transportation services visit (one-way trip) [Procedure code T2003 is reported on a separate detail from T1015-U9.]

The following modifiers provide information about the practitioner.

AJ	Clinical social worker
AH	Clinical psychologist
GC	Service performed in part by a resident under the direction of a teaching physician
GE	Service performed by a resident without the presence of a teaching physician, under the primary care exception
HN	Non-physician with bachelor's degree who is not a clinical psychologist
HO	Non-physician with master's degree who is not a clinical psychologist (including LISW)
HP	Non-physician with doctoral degree who is not a clinical psychologist (including LISW)
SA	Certified nurse practitioner rendering service in collaboration with a physician
SB	Certified nurse-midwife
UC	Clinical nurse specialist

Individual Options Waiver Program, Waiver Nursing, OAC Chapter 5160-40

HQ	Service delivered in a group setting [reported with procedure code T1002 or T1003] [Payment as a group rate is the lesser of the submitted charge or 75% of the Medicaid maximum.]
TU	Visit [reported with procedure code T1002 or T1003] that is claimed in its entirety as overtime
U2	Second visit made on the same date for the same type of service [reported with procedure code T1002 or T1003]
U3	Each additional visit beyond the second made on the same date for the same type of service [reported with procedure code T1002 or T1003]
U4	Visit lasting more than 12 hours but not more than 16 hours [reported with procedure code T1002 or T1003]
U9	RN assessment service [reported with procedure code G0493]
UA	Visit [reported with procedure code T1002 or T1003] that is claimed in part as overtime

SELF Waiver Program, Nursing Delegation, OAC Chapter 5160-41

U9	RN assessment service [reported with procedure code G0493]

Level One Waiver Program, Nursing Delegation, OAC Chapter 5160-42

U9	RN assessment service [reported with procedure code G0493]

Ohio Home Care Waiver Program; Home Care Attendant Services (HCAS), OAC Rule 5160-46-06.1

HQ	Service delivered in a group setting [reported with procedure code S5125][Payment as a group rate is the lesser of the submitted charge or 75% of the Medicaid maximum.]
TU	HCAS visit [reported with procedure code S5125] that is claimed in its entirety as overtime
U2	Second HCAS visit made to an individual on the same date of service [reported with procedure code S5125]
U3	The same provider submits a claim for three or more HCAS visits to an individual for the same date of service [reported with procedure code S5125]
U8	HCAS visit in lieu of intermittent nursing, for units of service that are HCAS/PC
UA	Visit [reported with procedure code T1002, T1003, or T1019] that is claimed in part as overtime

Ohio Home Care Waiver Program; OAC Rule 5160-46-06

HQ	Service delivered in a group setting [reported with procedure code T1002, T1003, or T1019] [Payment as a group rate is the lesser of the submitted charge or 75% of the Medicaid maximum.]
TU	Visit [reported with procedure code T1002, T1003, or T1019] that is claimed in its entirety as overtime
U2	Second visit made to an individual on the same date of service [reported with procedure code T1002, T1003, or T1019]
U3	The same provider submits a claim for three or more visits to an individual on the same date for the same type of service [reported with procedure code T1002, T1003, or T1019]
U4	Single visit lasting more than 12 hours but not more than 16 hours [reported with procedure code T1002, T1003, or T1019]
U6	Used with HCPCS code S5170 for a therapeutic or kosher home delivered meal
U8	HCAS visit in lieu of intermittent nursing, for units of service that are HCAS/PC
UA	Visit [reported with procedure code T1002, T1003, or T1019] that is claimed in part as overtime

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