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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 | Effective 1/1/24 - Reported to identify Observation Services for Behavioral Health/Substance Use Disorders and COVID-19 Administration codes. |
| 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 Behavioral Health Services, OAC rule 5160-2-76 for Dates of Service 8/1/2017 THROUGH 12/31/2023**

|    |   |
|----|---|
| HE | Outpatient behavioral health service<br>[Modifier HE is reported in conjunction with other appropriate modifiers. See "Applicable Modifiers for OPHBH Services Provided by Outpatient Hospitals" at <a href="http://medicaid.ohio.gov">http://medicaid.ohio.gov</a> (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).] |
|----|---|

**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<br>[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 Healthcchek (EPSDT)   |
| E1 | Eyelid, upper left   |
| E2 | Eyelid, lower left   |
| E3 | Eyelid, upper right  |
| 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,<br>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 Healthчек (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 Healthчек (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**

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|--|---|
|  | <p>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.</p> <p>The appendix to OAC rule 5160-15-28 gives a succinct summary.<br/> <a href="http://codes.ohio.gov/oac/5160-15-28">[http://codes.ohio.gov/oac/5160-15-28, 'Click to view Appendix']</a></p> |
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**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<br>[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                                 |



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***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<br>[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)<br>[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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