Medicaid Information Technology System

Release Date: 11/28/2011
Revision: 01/01/2017

Modifiers Recognized by Ohio Medicaid

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 on 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, the Centers for Medicaid and Medicare Services, and the American Society of Anesthesiologists.

ODM also recognizes Medicaid state specific *U* HCPCS modifiers that are tailored toward a state's Medicaid specific payment policy. These state specific modifiers are designed for Medicaid states to use as they define when there is no other modifier that meets the description or policy purpose. In some instances, 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 claims for various services. Not every modifier, however, can be used with every service or supply code in a group. Using an inappropriate modifier for a service or supply billed or a modifier Ohio Medicaid does not recognize will cause a line item denial.

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 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
- 50....... Bilateral procedure performed
- 51....... Multiple procedure performed
- 58....... Staged or related procedure or service by same physician during the postoperative period
- 59....... Distinct procedural service. (Effective 1/1/2017, ODM requires modifier 59 on subsequent births when billing for more than one birth (twins or triplets)).
- 62....... Co-surgery (TBD)
- 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 [valid only for physicians]
- AA...... Anesthesia service personally furnished by an anesthesiologist
- AD...... Medical supervision by a physician: more than four concurrent anesthesia procedures
- AS...... Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery (January 01, 2017)

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
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 ...... Nurse practitioner rendering service in collaboration with a physician
SB ...... Nurse midwife
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
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…… Separate Encounter, a service that is distinct because it occurred during a separate encounter (January 01, 2016)

XP……Separate Practitioner, a service that is distinct because it was performed by a different practitioner (January 01, 2016)
XS……Separate Structure, a service that is distinct because it was performed on a separate organ/structure (January 01, 2016)
XU……Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service (January 01, 2016)

General provisions, OAC Chapter 5160-1

GT…….Telemedicine distant site
GQ……Telemedicine originating site

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 92004 and 92014]

Other licensed professional services, OAC Chapter 5160-8 titled Limited Practitioner Services

AE……Registered dietitian
AH......Clinical psychologist
AJ.......Clinical social worker
HN......Bachelor's degree level
HO .....Master's degree level
HP......Doctoral degree level
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

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……Replacement of a part for DME item furnished as part of a repair
RP......Repair or replacement
RR......Rental
RT......Right side [used to identify procedures performed on the right side of the body]
U1 ......Delivery of service in a personal residence
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
90.......Reference [outside] laboratory
91.......Repeat laboratory procedure or service performed on the same day
QW.....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……Beyond fourteen 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……Used to identify a visit conducted by a registered nurse (RN) for the provision of a PDN nursing service billed to Ohio Medicaid. [Reported with procedure code T1000]
TE……Used to identify a visit conducted by a licensed practical nurse (LPN) for the provision of a PDN nursing service billed to Ohio Medicaid. [Reported with procedure code T1000]
TU……Used to indicate that the entire PDN (T1000) visit conducted by the non-agency RN or LPN is being billed as overtime
UA……Used to indicate that a portion of the PDN (T1000) visit conducted by the non-agency RN or LPN is being billed 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)

RN Assessment and RN Consultation services, OAC Chapter 5160-12:

U9……Used when an RN consultation service is performed. [Reported with procedure code T1001]

Ohio home care waiver program; including home care attendant services (HCAS), OAC Chapter 5160-46:

HQ……Modifier must be used when a provider submits a claim for billing code T1002, T1003, T1019 or S5125 if the service was delivered in a group setting. Reimbursement as a group rate shall be the lesser of the provider's billed charge or 75 percent of the Medicaid maximum.
TU……Modifier must be used when a provider submits a claim for billing code T1002, T1003, T1019 or S5125 and the entire claim is being billed as overtime.
UA……Modifier must be used when a provider submits a claim for billing code T1002, T1003, T1019 or S5125 and only a portion of the claim is being billed as overtime.
U2……Modifier must be used when a provider submits a claim for a second claim for billing code T1002, T1003, T1019 or S5125 to an individual enrolled on the Ohio home care waiver for the same date of service.
U3……Modifier must be used when the same provider submits a claim for billing code T1002, T1003, T1019 or S5125 for three or more visits to an individual enrolled on the Ohio home care waiver for the same date of service.
U4……Modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 for a single visit that was more than twelve hours in length but did not exceed sixteen hours.

U8……Modifier must be used when a provider submits a claim for an HCAS visit that is in lieu of intermittent nursing as described in paragraph (A)(6) of this rule, and for units of service that are HCAS/PC.

Transitions DD waiver program, OAC Chapter 5160-41:

HQ……Modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement as a group rate shall be the lesser of the provider's billed charge or 75 percent of the Medicaid maximum.

TU……Modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 and the entire claim is being billed as overtime.

UA……Modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 and only a portion of the claim is being billed as overtime.

U2……Modifier must be used when a provider submits a claim for a second claim for billing code T1002, T1003 or T1019 to an individual enrolled on the Ohio home care waiver for the same date of service.

U3……Modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to an individual enrolled on the Ohio home care waiver for the same date of service.

U4……Modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 for a single visit that was more than twelve hours in length but did not exceed sixteen hours.

Individual Options program, waiver nursing, OAC 5160-41:

HQ……Modifier must be used when a provider submits a claim for billing code T1002 or T1003 if the service was delivered in a group setting. Reimbursement as a group rate shall be the lesser of the provider's billed charge or 75 percent of the Medicaid maximum.

TU……Modifier must be used when a provider submits a claim for billing code T1002 or T1003 and the entire claim is being billed as overtime.

UA……Modifier must be used when a provider submits a claim for billing code T1002 or T1003 and only a portion of the claim is being billed as overtime.

U2……Modifier must be used when a provider submits a claim for a second claim for billing code T1002 or T1003 to an individual enrolled on the Ohio home care waiver for the same date of service.

U3……Modifier must be used when the same provider submits a claim for billing code T1002 or T1003 for three or more visits to an individual enrolled on the Ohio home care waiver for the same date of service.

U4….. Modifier must be used when a provider submits a claim for billing code T1002 or T1003 for a single visit that was more than twelve hours in length but did not exceed sixteen hours

Transportation services, 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 pricing, and some convey other information. Rarely used or unlikely combinations of procedure code and modifier may require human intervention in the adjudication of the claim. Because of the multiplicity of possibilities, specific modifiers are not listed here.

Rural Health Clinic (RHC) services, OAC Chapter 5160-28

U1 ...... Medical services encounter [reported with procedure code T1015]

Federally Qualified Health Center (FQHC) services, OAC Chapter 5160-28

[The following modifiers are reported with procedure code T1015]

U1 ...... Medical services encounter
U2 ...... Dentistry encounter
U3 ...... Mental health services encounter
U4 ...... Physical or occupational therapy encounter
U5 ...... Speech pathology and audiology services encounter
U6 ...... Podiatry encounter
U7 ...... Optometrist or optician services encounter
U8 ...... Chiropractic services encounter
U9 ...... Transportation encounter (must bill T2003 underneath the encounter T1015 U9 billed)
UA...... Telemedicine encounter (originating site fee only)

Note: All of the modifiers listed for professional claims can also be reported on outpatient hospital claims. Only the following modifiers, however, affect outpatient hospital claims reimbursement logic.

Outpatient hospital services, OAC Chapter 5160-2 (Appendix A to rule 5160-2-21)

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