



Modifiers Used in Professional Claims

Modifiers are two-character codes used along with a procedure or service code to provide additional information about that procedure or service. Care must be taken in reporting modifiers on claims, because using a modifier incorrectly can result in the denial of payment for an individual procedure or service or for an entire claim. The Ohio Department of Medicaid (ODM) accepts many but not all the modifiers promulgated by such nationally recognized sources as the American Medical Association, the Centers for Medicaid and Medicare Services, and the American Society of Anesthesiologists.

In addition, ODM accepts certain modifiers that are tailored to the specific requirements of the Ohio Medicaid payment system; the first character of these modifiers is *U*. The same modifier can take on different meanings when it is used with different procedure codes. The modifier U1 used with certain DME codes, for example, indicates that the place of service was a personal residence; when it is used with the general FQHC procedure code T1015, it specifies that the service was medical in nature.

Medicaid rules governing professional 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 are used in claims for the various services. Not every modifier, however, can be used with every procedure code in a group. In fact, using an inappropriate modifier may cause the denial of a line item on a claim. For example, for radiology procedure codes (which are a subset of physician service codes), modifiers 26 and TC are used to indicate the professional and technical components of a service respectively; one of the modifiers SA, SB, or UC may also be reported along with 26 if the professional component is provided by an advanced practice nurse (APN) operating within the APN's scope of practice. Separate-procedure modifier 59 and site modifiers LT and RT are also accepted with radiology procedure codes where appropriate. Inclusion of any other modifier (such as 76, F2, GC, GE, PI, PS, or T5) with a radiology procedure code will cause a denial.

Physician services, OAC Chapter 5101:3-4

- 24Unrelated evaluation and management service by the same physician during the postoperative period
- 25Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
- 26Professional component of a procedure that has both a technical and a professional component
- 50Bilateral procedure performed
- 51Multiple procedure performed
- 58Staged or related procedure or service by same physician during the postoperative period
- 59Distinct procedural service
- 78Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period
- 79Unrelated procedure by same physician during the postoperative period
- 80Assistant-at-surgery service [valid only for physicians]
- AAAnesthesia service personally furnished by an anesthesiologist
- ADMedical supervision by a physician: more than four concurrent anesthesia procedures
- AHClinical psychologist

AJClinical social worker
 EPService provided under Healthchek (EPSDT)
 E1Eyelid, upper left
 E2Eyelid, lower left
 E3Eyelid, upper left
 E4Eyelid, lower right
 FALeft hand, thumb
 F1Left hand, second digit
 F2Left hand, third digit
 F3Left hand, fourth digit
 F4Left hand, fifth digit
 F5Right hand, thumb
 F6Right hand, second digit
 F7Right hand, third digit
 F8Right hand, fourth digit
 F9Right hand, fifth digit
 GCService performed in part by a resident under the direction of a teaching physician
 GEService performed by a resident without the presence of a teaching physician under the
 primary care exception rule
 HNBachelor's degree level
 HOMaster's degree level
 HPDoctoral degree level
 LCLeft circumflex coronary artery
 LDLeft anterior descending coronary artery
 LTLeft side [used to identify procedures performed on the left side of the body]
 QKMedical direction of two, three, or four concurrent anesthesia procedures involving qualified
 individuals
 QXCRNA with medical direction by a physician or anesthesia assistant with medical direction
 by an anesthesiologist
 QWCLIA waived version of a high- or moderate-complexity laboratory procedure
 QYMedical direction of one CRNA by an anesthesiologist
 QZCRNA without medical direction by a physician
 RCRight coronary artery
 RTRight side [used to identify procedures performed on the right side of the body]
 SANurse practitioner rendering service in collaboration with a physician
 SBNurse midwife
 TALeft foot, great toe
 T1Left foot, second digit
 T2Left foot, third digit
 T3Left foot, fourth digit
 T4Left foot, fifth digit
 T5Right foot, great toe
 T6Right foot, second digit
 T7Right foot, third digit
 T8Right foot, fourth digit
 T9Right foot, fifth digit
 TCTechnical component of a procedure performed in a non-hospital setting
 THObstetrical service, prenatal or post-partum
 UBTransport of a critically ill or injured patient over 24 months of age
 UCClinical nurse specialist
 UDPhysician assistant

Vision care services, OAC Chapter 5101:3-6

- 52Spectacle fitting service for less than a complete pair of spectacles
- UBComprehensive 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]

Limited practitioner services, OAC Chapter 5101:3-8

- QXCRNA with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist
- QWCLIA waived version of a high- or moderate-complexity laboratory procedure
- QYMedical direction of one CRNA by an anesthesiologist
- QZCRNA without medical direction by a physician
- SANurse practitioner rendering service in collaboration with a physician
- SBNurse midwife
- UBTransport of a critically ill or injured patient over 24 months of age
- UCClinical nurse specialist

Medical supplies, durable medical equipment, orthoses, and prostheses, OAC Chapter 5101:3-10

- BONutrition administered orally without a tube
- LTLeft side [used to identify procedures performed on the left side of the body]
- QEPrescribed oxygen < 1 LPM
- QFPrescribed oxygen > 4 LPM, portable
- QGPrescribed oxygen > 4 LPM
- RPRepair or replacement
- RRRental
- RTRight side [used to identify procedures performed on the right side of the body]
- U1Delivery of service in a personal residence
- UEUsed durable medical equipment

Independent laboratory, portable X-ray, or independent diagnostic testing facility (IDTF) services, OAC Chapter 5101:3-11

- 26Professional component of a procedure that has both a technical and a professional component
- 26Clinical pathology interpretation of a clinical diagnostic procedure for which interpretation is separately reimbursable [applicable only to CPT procedure codes 83020, 83912, 84165, 84166, 84181, 84182, 85390, 85576, 86255, 86256, 86320, 86325, 86327, 86334, 86335, 87164, 87207, 88371, 88372, and 89060]
- 90Reference [outside] laboratory
- 91Repeat laboratory procedure or service performed on the same day
- QWCLIA waived version of a high- or moderate-complexity laboratory procedure
- TCTechnical component of a procedure that has both a technical and a professional component

Home health services, OAC Chapter 5101:3-12

- HQGroup visit
- U1Infusion therapy [reported with procedure code G0154]
- U2Second visit made on the same date for the same type of service
- U3Each additional visit beyond the second made on the same date for the same type of service
- U5Service provided under Healthchek (EPSDT)

Private duty nursing services, OAC Chapter 5101:3-12

- HQ.....Group visit
- 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.....Increased service provided under Healthchek (EPSDT)
- U6.....Increased service provided with authorization

Transportation services, OAC Chapter 5101:3-15

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 5101:3-16

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

Federally Qualified Health Center (FQHC) services, OAC Chapter 5101:3-28

[The following modifiers are reported with procedure code T1015.]

- U1.....Medical services encounter
- U2.....Dentistry encounter
- U3.....Mental health services encounter
- U4.....Physical 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



Note: All of the modifiers listed for professional claims can also be reported on outpatient hospital claims. Only the following modifiers, however, are recognized for the purpose of paying outpatient hospital claims.

Outpatient hospital services, OAC Chapter 5101:3-2 (Appendix A to rule 5101:3-2-21)

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