Modifiers: Approved List

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Below is a list of approved modifier codes for use in billing Medi-Cal. Modifiers not listed in this section are unacceptable for billing Medi-Cal.

Modifier Overview

Some modifier information in this section is taken from the CPT® code book (*Current Procedural Terminology* code book) and HCPCS code book (*Healthcare Common Procedure Coding System, Level II*)

Discontinued Modifiers

Medicaid programs have traditionally tailored modifiers for their state's needs. These interim (or local) modifiers are being phased out under Health Insurance Portability and Accountability Act (HIPAA) requirements. Refer to the list of discontinued and invalid modifiers at the end of this section.

National Correct Coding Initiative

Medi-Cal claims are subject to a set of claims processing edits that are federally mandated. ‹‹The edits, controlled by the Centers for Medicare & Medicaid Services (CMS), are part of the Medicaid National Correct Coding Initiative (NCCI).

Modifiers relevant to the NCCI edit methodology are designated with the dagger symbol (†) in the following modifier list.›› See the *Correct Coding Initiative: National* section for instructions regarding the use of NCCI-associated modifiers.

Note: ‹‹*Treatment Authorization Requests* (TARs), *Service Authorization Requests* (SARs), *CMS-1500* and *UB-04* claims may have more than one NCCI associated modifier applied to a claim line only when medically necessary, as documented in the medical record, and in accordance with the Medicaid NCCI program and HCPCS and CPT guidelines for the modifier and procedure code combination. Additionally, placement of modifiers on the claim is important. An NCCI-associated modifier should not appear in the first modifier position (next to the procedure code) unless it is the only modifier on that claim line.››

Table of Approved Modifiers

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
22*	Increased procedural services	May be used with computed tomography (CT) codes when additional slices are required or a more detailed evaluation is necessary. Used by Local Educational Agency (LEA) to denote an additional 15-minute service increment rendered beyond the required initial service time. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information. Surgical: May be billed when procedures involve significantly increased operative complexity and/or time in a significantly altered surgical field resulting from the effects of prior surgery, marked scarring, adhesions, inflammation, or distorted anatomy, irradiation, infection, very low weight (for example, neonates and small infants less than 10 kg) and/or trauma (as documented in a recipient's medical record). Justification is required on the claim. Anesthesia: Prone position, base units less than or equal to three units.
‹‹24*†››	Unrelated E&M service by the same physician or other qualified health care professional during a postoperative period	Not Applicable

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
‹‹25*†››	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service	Family PACT providers must use modifier 25 to bill an E&M code with E&C services for the same date of service. For specific requirements, see the *Office Visits: Evaluation and Management and Education Counseling Services* section of the Family PACT Policies, Procedures and Billing Instructions Manual.
26*	Professional component	Not Applicable
‹‹27*†››	Increased procedural services	Not Applicable
33*	Preventive service	Claims billed using modifier 33 are not subject to specific ICD-10-CM inclusion and/or exclusion criteria. Use of modifier 33 indicates the service was provided in accordance with a U.S. Preventive Services Task Force A or B recommendation.
47*	Anesthesia by surgeon	Do not use as a modifier for anesthesia codes.
50*	Bilateral procedure	Not Applicable
51*	Multiple procedures	Not Applicable
52*	Reduced services	Surgical: For use with surgery codes 66820 thru 66821, 66830, 66840, 66850, 66920, 66930, 66940 and 66982 thru 66985. Requires “By Report” documentation. Used by LEA to denote an annual re-assessment. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information. LEA does not require “By Report” documentation.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
53*	Discontinued procedure	Requires “By Report” documentation.
54*	Surgical care only	Not Applicable
55*	Postoperative management only	Not Applicable
57†	Decision for surgery (major surgery only, day before or day of procedure)	Not Applicable
58*†	Staged or related procedure or service by the same physician during the postoperative period	May be used with codes 15002 thru 15429 and 52601 to address subsequent part(s) of a staged procedure.
59*†	Distinct procedural service	Used primarily with codes 36818 thru 36819 and 76816. ‹‹Used for CPT 4 codes 29000 thru 29086, 29105 thru 29131, 29305 thru 29450 or 29505 thru 29515 when fiberglass is used as a casting or splinting material. See the Surgery: Musculoskeletal System section in the appropriate Part 2 manual for more information.››
62*	Two surgeons	Not Applicable
66*	Surgical team	Not Applicable
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia (to be reported by hospital outpatient department or surgical clinic, only)	To be reported by hospital outpatient department or surgical clinic only. Requires “By Report” documentation.
74	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia	To be reported by hospital outpatient department or surgical clinic only. Requires “By Report” documentation.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
76	Repeat procedure or service by same physician	Not Applicable
77	Repeat procedure by another physician	Not Applicable
78*†	Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period	Not Applicable
79*†	Unrelated procedure or service by the same physician during the postoperative period	Not Applicable
80*	Assistant surgeon	Not Applicable
90*	Reference (outside) laboratory	Only specified providers may use this modifier.
91*†	Repeat clinical diagnostic laboratory test	Not Applicable
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system	Providers must document in the patient's medical chart that the patient has given a written or verbal consent to the audio-only telemedicine encounter.
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	Not Applicable

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
99*	Multiple modifiers	Used when two or more modifiers are necessary to completely delineate a service; the multiple modifiers used must be explained in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. Do not bill 99 when billing split-billable claims without a modifier (professional and technical service component) or with modifier 26 (professional component) and TC (technical component). The claim will be denied. Also used in special circumstances as specified by the Department of Health Care Services (DHCS). For an example, refer to the *Surgery Billing Examples: UB-04* or *Surgery Billing Examples: CMS-1500* sections in the appropriate Part 2 manual.
AA	Anesthesia performed by an anesthesiologist	N/A
AE	Registered dietician	Registered dietician

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
AG	Primary physician	Surgical: Used to denote a primary surgeon. In the case of multiple primary surgeons, two or more surgeons can use modifier AG for the same patient on the same date of service if the procedures are performed independently and in different specialty areas. This does not include surgical teams or surgeons performing a single procedure requiring different skills. An explanation of the clinical situation and operative reports by all surgeons involved must be included with the claim. Used by LEA to denote licensed physicians. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
AH	Clinical psychologist	Used by LEA to denote licensed psychologists, licensed educational psychologists, credentialed school psychologists and clinical psychologists. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
AI	Principal physician of record	Allowable for all procedure codes.
AJ	Clinical social worker	Used by LEA to denote licensed clinical social workers and credentialed school social workers. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination	Use only for ophthalmology.
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Certified nurse midwives (CNM) may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by a licensed physician and surgeon.
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD	N/A
AZ	Physician providing a service in a dental health profession shortage area for the purpose of an electronic health record incentive payment	N/A
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant	Used by LEA to denote licensed occupational therapy assistant. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant)	Used by LEA to denote physical therapist assistant. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
‹‹CR	Catastrophe/disaster related	Used by LEA to denote COVID-19 vaccine counseling-only visit. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.››
CS	Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test	N/A

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
DA	Oral health assessment by a licensed health professional other than a dentist	Not Applicable
DS	Ambulance service origin code D (diagnostic or therapeutic site other than P or H when these are used as origin codes) with ambulance service destination code S (scene of accident or acute event)	Medical transport dry run. When billed with modifier QN, modifier DS must be in the first modifier position.
‹‹E1†››	Upper left, eyelid	Use modifier SC with CPT code 68761 (closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery; by plug, each) to indicate use of temporary collagen punctal plugs. Modifiers E1 thru E4 are used in connection with permanent silicone punctal plugs and procedures on the eyelids.
‹‹E2†››	Lower left, eyelid	Use modifier SC with CPT code 68761 (closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery; by plug, each) to indicate use of temporary collagen punctal plugs. Modifiers E1 thru E4 are used in connection with permanent silicone punctal plugs and procedures on the eyelids.
‹‹E3†››	Upper right, eyelid	Use modifier SC with CPT code 68761 (closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery; by plug, each) to indicate use of temporary collagen punctal plugs. Modifiers E1 thru E4 are used in connection with permanent silicone punctal plugs and procedures on the eyelids.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
‹‹E4†››	Lower right, eyelid	Use modifier SC with CPT code 68761 (closure of lacrimal punctum; by thermocauterization, ligation, or laser surgery; by plug, each) to indicate use of temporary collagen punctal plugs. Modifiers E1 thru E4 are used in connection with permanent silicone punctal plugs and procedures on the eyelids.
EP	Service provided as part of a Medicaid early and periodic screening diagnostic and treatment (EPSDT).	Not Applicable
ET	Emergency services	Not Applicable
‹‹F1†››	Left hand, second digit	Not Applicable
‹‹F2†››	Left hand, third digit	Not Applicable
‹‹F3†››	Left hand, fourth digit	Not Applicable
‹‹F4†››	Left hand, fifth digit	Not Applicable
‹‹F5†››	Right hand, thumb	Not Applicable

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
F6†	Right hand, second digit	Not Applicable
F7†	Right hand, third digit	Not Applicable
F8†	Right hand, fourth digit	Not Applicable
F9†	Right hand, fifth digit	Not Applicable
FA†	Left hand, thumb	Not Applicable
FP	Family planning services	Add modifier to HCPCS and CPT codes as appropriate: Z1032 thru Z1038 + FP Z6200 thru Z6500 + FP 59400 + FP 59510 + FP 59610 + FP 59618 + FP 99202 thru 99215 + FP ‹‹99242 thru 99245 + FP›› 99281 thru 99285 + FP ‹‹99341, 99342 and 99344 thru 99353›› + FP 99384 + FP 99394 + FP
FQ	The service was furnished using audio-only communication technology	Not Applicable

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
FR	The supervising practitioner was present through two-way, audio/video communication technology	N/A
FS	Split (or shared) evaluation and management visit	N/A
FT	‹‹Unrelated evaluation and management (e/m) visit on the same day as another e/m visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (report when an e/m visit is furnished within the global period but is unrelated, or when one or more additional e/m visits furnished on the same day are unrelated)››	N/A
GC	Physician services provided by a resident and teaching physician	N/A
GN	Service delivered under an outpatient speech-language pathology plan of care	Used by LEA to denote licensed speech-language pathologists and credentialed speech-language pathologists. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
GO	Service delivered under an outpatient occupational therapy plan of care	Used by LEA to denote licensed occupational therapists. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
GP	Service delivered under an outpatient physical therapy plan of care	Used by LEA to denote licensed physical therapists. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
GQ	Via asynchronous telecommunications system	Used to denote store-and-forward telecommunications system.
GT	Service rendered via interactive audio and video telecommunications systems	Used to denote real-time telecommunications system.
GU	Waiver of liability statement issued as required by payer policy, routine notice	N/A
GX	Notice of liability issued, voluntary under payer policy	N/A
GY	Item or service statutorily excluded; does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit	Used to denote that the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) recipient with full-scope Medi-Cal has started a physician-ordered course of treatment before reaching 21 years of age and the recipient is to complete the course of the prescribed treatment. Use of GY only applies to medical/surgical care required for the treatment and the resolution of the acute episode.
HA	Child/adolescent program	Used by pediatric subacute facility or provider of palliative care to denote that the patient is a child.
HB	Adult program, nongeriatric	Used by adult subacute facility or provider of palliative care to denote that the patient is an adult.
‹‹HC	Adult program, geriatric	Use when billing with a Multipurpose Senior Services Program (MSSP) code.››
HD	Pregnant/parenting women's program	Used when billing for either a positive or negative depression screening for pregnant or postpartum recipients.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
HL	Intern	Used by LEA to denote associate marriage and family therapists. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
HM	Less than bachelor degree level	Used to denote that the rendering provider is certified as a Sign Language Interpreter. Used by LEA to denote speech-language pathology assistants and registered associate clinical social workers. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
HN	Ambulance service origin code H (hospital) with ambulance service destination code N (skilled nursing facility)	Ambulance modifier H may be used in conjunction with modifier N (H+N) to indicate transportation from an acute care hospital to a skilled nursing facility. When billed with modifier QN, modifier HN must be in the first modifier position.
HO	Masters degree level	Used by LEA to denote program specialists. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
HT	Multi-disciplinary team	Used by California Community Transition (CCT) Demonstration providers to denote CCT services.
J4	DMEPOS item subject to DMEPOS competitive bidding program that is furnished by a hospital upon discharge	Allowable but not required for all DME codes.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
J5	Off-the-shelf orthotic subject to DMEPOS Competitive Bidding Program that is furnished as part of a physical therapist or occupational therapist professional service	N/A
JW	Drug amount discarded/not administered to any patient	Allowable with the exception of the following: • Drugs that are not separately payable, such as packaged Outpatient Prospective Payment System (OPPS) drugs or drugs administered in the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) setting since they are not generally separately billable • Drugs paid under the Part B drug Competitive Acquisition Program (CAP) (the CAP remains on hold and there is currently no list of CAP medications) • Claims for hospital inpatient admissions that are billed under the Inpatient Prospective Payment System (IPPS) • When the actual dose administered is less than the HCPCS billing unit, as payment will not be made using fractional billing units and this may result in overpayment For detailed billing policy, see the *Modifiers* section of the Part 2 Provider Manual.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
KC	Replacement of special power wheelchair interface	N/A
KX	Requirements specified in the medical policy have been met	Specific required documentation on file. Used by Diabetes Prevention Program (DPP) organizations to indicate DPP services were rendered through video-conferencing, online, distance learning or other virtual tool. Used with CPT code 96110 (developmental screening, with scoring and documentation, per standardized instrument) to denote an autism screening.
LC†	Left circumflex coronary artery	Not Applicable
LD†	Left anterior descending coronary artery	Not Applicable
LM†	Left main coronary artery	Not Applicable
LT†	Left side (used to identify procedures performed on the left side of the body)	Not Applicable
MA	Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition	Not Applicable
MB	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access	Not Applicable

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
NB	Nebulizer system, any type, FDA-cleared for use with specific drug	N/A
NU	New equipment	Used to denote purchase of new equipment.
P1*	A normal, healthy patient	Used to denote anesthesia services provided to a normal, uncomplicated patient.
P3*	A patient with severe systemic disease	Used to denote anesthesia services provided to a patient with severe systemic disease.
P4*	A patient with severe systemic disease that is a constant threat to life	Used to denote anesthesia services provided to a patient with severe systemic disease that is a constant threat to life.
P5*	A moribund patient who is not expected to survive without the operation	Used to denote anesthesia services provided to a moribund patient who is not expected to survive without the operation.
PA	Surgery, wrong body part	Allowable for all procedure codes.
PB	Surgery, wrong patient	Allowable for all procedure codes.
PC	Wrong surgery on patient	Allowable for all procedure codes.
PI	Positron emission tomography (PET) or PET/computed tomography (CT) to inform initial treatment strategy of tumors	Allowable but not required for all radiology procedure codes.
PS	PET or PET/CT to inform the subsequent treatment strategy of cancerous tumors	Allowable but not required for all radiology procedure codes.
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure	N/A

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
QA	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than one liter per minute (LPM)	N/A
QB	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds four LPM and portable oxygen is prescribed	N/A
QE	Prescribed amount of stationary oxygen while at rest is less than one LPM	N/A
QF	Prescribed amount of stationary oxygen while at rest exceeds four LPM and portable oxygen is prescribed	N/A
QG	Prescribed amount of stationary oxygen while at rest is greater than four LPM	Use this modifier if portable oxygen is not prescribed.
QJ	Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 CFR 411.4(B)	Evaluation and Management approved procedure codes for Justice-Involved (JI) services shall receive the 10 percent bump (enhanced payment) when the in-reach provider bills appropriately with modifier QJ and the Correctional Facility (CF) as the place of service.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	**Note:** Modifier QK will also be used when billing for the supervision of one anesthesia procedure.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
QN	Ambulance service furnished directly by a provider of services	May be used in conjunction modifier HN for medical transportation, which is the combination of ambulance service origin code H (hospital) and ambulance service destination code N (skilled nursing facility).
QP	Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002 thru 80019, G0058, G0059 and G0060	Used for lab codes where documentation is on file showing that the test was ordered individually.
QR	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is greater than four LPM	Use this modifier if portable oxygen is not prescribed.
QS	Monitored anesthesia care service	Used by California Children's Services (CCS) to denote monitored anesthesia care.
QW	CLIA waived test	Used to indicate that the provider is performing testing for the procedure with the use of a specific test kit from manufacturers identified by the Centers for Medicare & Medicaid Services (CMS).
QX	CRNA service: with medical direction by a physician	N/A
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	N/A
QZ	CRNA service: without medical direction by a physician	N/A

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
RA	Replacement	Used to indicate replacement vision care frames and lenses.
RB	Replacement as part of a repair	Used to indicate replacement parts during repair of Durable Medical Equipment (DME), including parts of eyeglass frames.
RC†	Right coronary artery	Not Applicable
RI †	Ramus intermedius	Not Applicable
RR	Rental	Used to indicate when DME is to be rented.
RT†	Right side (used to identify procedures performed on the right side of the body)	Not Applicable
SA	Nurse practitioner rendering service in collaboration with a physician	Not Applicable
SB	Nurse midwife	Used when Certified Nurse Midwife service is billed by a physician, hospital outpatient department or organized outpatient clinic (not by CNM billing under his or her own provider number).
SC	Medically necessary service or supply	Not Applicable
SE	State and/or federally funded programs/services	Not Applicable
SK	Member of high-risk population (use only with codes for immunization)	Not Applicable
SL	State-supplied vaccine	Used for Vaccines For Children (VFC) program recipients through 18 years of age.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
T1†	Left foot, second digit	Not Applicable
T2†	Left foot, third digit	Not Applicable
T3†	Left foot, fourth digit	Not Applicable
T4†	Left foot, fifth digit	Not Applicable
T5†	Right foot, great toe	Not Applicable
T6†	Right foot, second digit	Not Applicable
T7†	Right foot, third digit	Not Applicable
T8†	Right foot, fourth digit	Not Applicable
T9†	Right foot, fifth digit	Not Applicable

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
TA†	Left foot, great toe	Not Applicable
TC	Technical component	Not Applicable
TD	Registered nurse (RN)	Used by LEA to denote licensed registered nurses, registered credentialed school nurses, certified public health nurses and certified nurse practitioners. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
TE	Licensed practical nurse (LPN)/Licensed vocational nurse (LVN)	Used by LEA to denote licensed vocational nurses. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information. Used to denote licensed vocational nurses providing services to children receiving palliative care services.
TG	Complex/high tech level of care	N/A
TH	Obstetrical treatment/services, prenatal or postpartum	Used to denote that the service rendered is ONLY for pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy. Modifier TH can be used for up to 60 days after termination of pregnancy.
TL	Early intervention/Individualized Family Services Plan (IFSP)	Used by LEA to denote that service is part of an Individualized Family Services Plan. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
TM	Individualized Education Plan (IEP)	Used by LEA to denote that service is part of individualized education plan. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
TS	Follow-up service	Used by LEA to denote an amended re-assessment. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
TT	Individualized service provided to more than one patient in same setting	Used by Home and Community-Based Services (HCBS) Waiver Program to denote services provided to two HCBS Nursing Facility/Acute Hospital (NF/AH) Waiver recipients who reside in the same residence. Also referred to as shared services.
TU	Special payment rate, overtime, (air ambulance transportation only), (emergency or non-emergency)	Used by medical transportation to bill for waiting time in excess of the first 15 minutes, in one-half (1/2) hour increments.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
U1	Medicaid level of care 1, as defined by each state	Used by HCBS Waiver Program to denote skilled nursing services A or B level of care. Also used with HCPCS code A4269 to indicate the type of spermicide (gel, jelly, foam, cream) and with J7304 for transdermal patch (norelgestromin and ethinyl estradiol). See the *Family Planning* section in the appropriate Part 2 manual or the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual for details. Also used for dyadic services and dyadic caregiver services. When billed with HCPCS codes H1011, H2015, H2027 and T1027, or to indicate dyadic caregiver services, modifier U1 must be in the first modifier position. Used with HCPCS code T2025 for MSSP to indicate administration expenses per month.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
U2	Medicaid level of care 2, as defined by each state	Used by HCBS Waiver Program to denote skilled nursing services A or B level of care. Used to denote services rendered by Community Health workers. Also used with HCPCS code A4269 to indicate the type of spermicide (suppository) and with J7304 for transdermal patch (levonorgestrel and ethinyl estradiol). See the *Family Planning* section in the appropriate Part 2 manual or the Family PACT PPBI manual for details. Used with HCPCS code T2025 for MSSP to indicate legal/paralegal consultation.
U3	Medicaid level of care 3, as defined by each state	Used to denote services rendered by Asthma Preventive Service providers. Used by HCBS Waiver Program to denote skilled nursing services A or B level of care. Also used with HCPCS code A4269 to indicate the type of spermicide (vaginal film). See the *Family Planning* section in the appropriate Part 2 manual or the Family PACT PPBI manual for details. Used with HCPCS code T2025 for MSSP to indicate non-medical transportation, per hour.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
U4	Medicaid level of care 4, as defined by each state	Also used with HCPCS code A4269 to indicate the type of spermicide (contraceptive sponge). See the *Family Planning* section in the appropriate Part 2 manual or the Family PACT PPBI manual for details. Used with HCPCS code T2025 for MSSP to indicate non-medical transportation one-way trip.
U5	Medicaid level of care 5, as defined by each state	Used with HCPCS code J3490 to indicate emergency contraceptive pills (ulipristal acetate). Also used with HCPCS code A4269 to indicate vaginal gel (lactic acid, citric acid and potassium bitartrate). See the *Family Planning* section in the appropriate Part 2 manual or the Family PACT PPBI manual for details.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
U6	Medicaid level of care 6, as defined by each state	Used by HCBS Waiver Program to separate California Community Transitions (CCT) services from other waiver services. Used with HCPCS code J3490 to indicate emergency contraceptive pills (levonorgestrel). See the *Family Planning* section in the appropriate Part 2 manual or the Family PACT PPBI manual for details. Also used by Family PACT (Planning, Access, Care and Treatment) Program with HCPCS codes 99401, 99402 and 99403 to indicate Education and Counseling (E&C) services. See the Family PACT PPBI manual for details.
U7	Medicaid level of care 7, as defined by each state	Used to denote services rendered by Physician Assistant (PA). Used by LEA to denote licensed physician assistants. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
U8	Medicaid level of care 8, as defined by each state	Required on all JI services billed to simplify JI claim identification and processing. Used with HCPCS code J3490 to indicate medroxyprogesterone acetate for contraceptive use.
U9	Medicaid level of care 9, as defined by each state	Used to denote services rendered by licensed midwife (LM).

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
UA	Medicaid level of care 10, as defined by each state	Used for surgical or non-general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code. Also used to indicate outpatient heroin detoxification services per visit, days 1 thru 7. See the *Heroin Detoxification Billing Codes* section for details.
UB	Medicaid level of care 11, as defined by each state	Used for surgical or general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code. Also used to indicate outpatient heroin detoxification services per visit, days 8 thru 21. See the *Heroin Detoxification Billing Codes* section for details.
UC	Medicaid level of care 12, as defined by each state	Used to indicate outpatient heroin detoxification services once per week, days 8 thru 21 (in lieu of UB). See the *Heroin Detoxification Billing Codes* section for details.
UD	Medicaid level of care 13, as defined by each state	Used by Section 340B providers to denote services provided or drugs purchased under this program.
UJ	Services provided at night	Used by medical transportation to indicate that services were provided between 7 p.m. and 7 a.m.
UN	Two patients served	Used to indicate that two patients were served in medical transportation.
UP	Three patients served	Used to indicate that three patients were served in medical transportation.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
UQ	Four patients served	Used to indicate that four patients were served in medical transportation.
UR	Five patients served	Used to indicate that five patients were served in medical transportation.
US	Six or more patients served	Used to indicate that six or more patients were served in medical transportation.
V4	Demonstration modifier 4	Not Applicable
V5	Any vascular catheter (alone or with any other vascular access)	Allowable for all procedure codes.
V6	Arteriovenous graft (or other vascular access not including a vascular catheter)	Allowable for all procedure codes.
V7	Arteriovenous fistula only (in use with two needles)	Allowable for all procedure codes.
XE*†	Separate encounter: a service that is distinct because it occurred during a separate encounter	Used when billing JI Care Management Bundle 5: Post-Transition Support.
XP*†	Separate practitioner: a service that is distinct because it was performed by a different practitioner	Not Applicable
XS*†	Separate structure: a service that is distinct because it was performed on a separate organ/structure	Not Applicable
XU*†	Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service	Not Applicable

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
YW	Not applicable. This is an interim (local) modifier.	Required professional experience (applies only to speech therapists and audiologists).
ZL	Not applicable. This is an interim (local) modifier.	This modifier is used to certify that initial comprehensive antepartum office visit occurred within 16 weeks of the last menstrual period (LMP) (up to and including pregnancies of 16 weeks and 0/7ths days gestation only). Used with HCPCS code Z1032 only. (Reimbursed only once during pregnancy – service limitation of once in nine months.) Use of this modifier adds $56.63 to reimbursement. Available only to Comprehensive Perinatal Services Program (CPSP) providers. For enrollment information, see *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* in the appropriate Part 2 manual.

Discontinued and Invalid Modifiers

Below is a list of discontinued and invalid modifier codes for use in billing Medi-Cal. Modifiers listed below are no longer acceptable for billing Medi-Cal.

Table of Discontinued/Invalid Modifiers

Discontinued/ Invalid Modifier	Discontinuation Date	Modifier Description
21	September 1, 2009	Prolonged evaluation and management services (see Evaluation and Management [E&M] section in the appropriate provider manual on how to bill for prolonged E&M visits).
60	May 1, 2009	Altered surgical field. Use modifier 22.
75	May 1, 2009	Concurrent care, services rendered by more than one physician.
AF	August 1, 2005	Anesthesia complicated by total body hypothermia above 30 degrees.
AN	February 1, 2009	Physician assistant service. Replaced by HIPAA compliant modifier U7.
‹‹MA	January 1, 2025	Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition
MB	January 1, 2025	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access
MC	January 1, 2025	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of electronic health record or clinical decision support mechanism vendor issues››

Table of Discontinued/Invalid Modifiers

Discontinued/ Invalid Modifier	Discontinuation Date	Modifier Description
‹‹MD	January 1, 2025	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances››
‹‹ME	January 1, 2025	The order for this service adheres to appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional››
‹‹MF	January 1, 2025	The order for this service does not adhere to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional››
‹‹MG	January 1, 2025	The order for this service does not have applicable appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional››
‹‹MH	January 1, 2025	N/A Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider››
V8	October 1, 2012	Infection present. Allowable for all procedure codes.
V9	October 1, 2012	No infection present. Allowable for all procedure codes.
Y1	November 1, 2005	Rental without sales tax (hearing aids).
Y2	November 1, 2005	Purchase or repair without sales tax (hearing aids).
Y6	November 1, 2005	Rental with sales tax (hearing aids).
Y7	November 1, 2005	Purchase, repair, mileage with sales tax (standard item, hearing aids).
YQ	November 1, 2005	Certified Nurse Midwife service (when billed by a physician, organized outpatient clinic or hospital outpatient department). Replaced by HIPAA compliant modifier SB.

Table of Discontinued/Invalid Modifiers (continued)

Discontinued/ Invalid Modifier	Discontinuation Date	Modifier Description
YR	February 1, 2009	Certified Nurse Midwife service (multiple modifiers) (when billed by a physician, organized outpatient clinic or hospital outpatient department). Replaced by HIPAA compliant modifier 99.
YS	November 1, 2005	Nurse Practitioner service. Replaced by HIPAA compliant modifier SA.
YT	February 1, 2009	Nurse Practitioner service (multiple modifiers). Replaced by HIPAA compliant modifier 99.
YU	February 1, 2009	Physician Assistant service (multiple modifiers). Replaced by HIPAA compliant modifier 99.
YV	July 1, 2001	‹‹Medi-Cal Waiver Program (MCWP) providers only. Administrative expenses when billed via the ASC X12N 837 v.5010 claim.››
Z1	Not applicable. This is an interim (local) modifier.	Additional air mileage in excess of 10 percent of standard airway mileage distances. Reason for additional mileage flown must be documented on the claim or on an attachment.
ZA	March 1, 2011	Anesthesia procedures complicated by unusual position or surgical field avoidance. **Note**: This local modifier was discontinued March 1, 2011. Use of this local modifier will result in claim denial.
ZB	March 1, 2011	Anesthesia (emergency services, healthy patient). **Note**: This local modifier was discontinued March 1, 2011. Use of this local modifier will result in claim denial.

Table of Discontinued/Invalid Modifiers (continued)

Discontinued/ Invalid Modifier	Discontinuation Date	Modifier Description
ZC	March 1, 2011	Anesthesia complicated by extracorporeal circulation. **Note**: This local modifier was discontinued March 1, 2011. Use of this local modifier will result in claim denial.
ZD	March 1, 2011	Emergency anesthesia (systemic disease).
ZE	March 1, 2011	Nurse anesthetist service; elective anesthesia: normal, healthy patient.
ZF	March 1, 2011	Anesthesia supervision.
ZG	March 1, 2011	Multiple anesthesia modifiers.
ZH	March 1, 2011	Nurse anesthetist service; anesthesia special circumstances: unusual position/field avoidance.
ZI	March 1, 2011	Nurse anesthetist service; anesthesia special circumstances: total body hypothermia.
ZJ	March 1, 2011	Nurse anesthetist service; emergency anesthesia: normal, healthy patient.
ZK	November 1, 2005	Primary Surgeon. Replaced by HIPAA compliant modifier AG.
ZM	November 1, 2010	Supplies and drugs for surgical procedures with other than general anesthesia or no anesthesia. Replaced by HIPAA compliant modifier UA.
ZN	November 1, 2010	Supplies and drugs for surgical procedures with general anesthesia. Replaced by HIPAA compliant modifier UB.
ZO	March 1, 2011	Nurse anesthetist service; anesthesia special circumstances: extracorporeal circulation.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Check the CPT Book for Guidelines in using this modifier
†	NCCI-associated