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 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 National Correct Coding Initiative (NCCI).

Modifiers relevant to the NCCI edit methodology are designated "NCCI associated" in the following modifier list. See the *Correct Coding Initiative: National* section for how NCCI affects reimbursement.

Note: NCCI does not allow more than one NCCI-associated modifier on a line for *Treatment Authorization Requests* (TARs), *CMS-1500* claims and *UB-04* claims. TARs and claims containing two or more NCCI-associated modifiers on the same line will be denied. In addition, 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* NCCI associated	Unrelated E&M service by the same physician or other qualified health care professional during a postoperative period	N/A
25* NCCI associated	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	N/A

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
26*	Professional component	N/A
27* NCCI associated	Increased procedural services	N/A
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	N/A
51*	Multiple procedures	N/A
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.
53*	Discontinued procedure	Requires “By Report” documentation.
54*	Surgical care only	N/A
55*	Postoperative management only	N/A

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
57†	Decision for surgery (major surgery only, day before or day of procedure)	N/A
58* NCCI associated	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* NCCI associated	Distinct procedural service	Used primarily with codes 36818 thru 36819 and 76816. Also used with other codes, as appropriate, for NCCI purposes.
62*	Two surgeons	N/A
66*	Surgical team	N/A
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.
76*	Repeat procedure or service by same physician	N/A
77*	Repeat procedure by another physician	N/A
78* NCCI associated	Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period	N/A

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
79* NCCI associated	Unrelated procedure or service by the same physician during the postoperative period	N/A
80*	Assistant surgeon	N/A
90*	Reference (outside) laboratory	Only specified providers may use this modifier.
91* NCCI associated	Repeat clinical diagnostic laboratory test	N/A
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	N/A
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.

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
AA	Anesthesia performed by an anesthesiologist	N/A
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/psychiatrists. 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 and credentialed school 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
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
DA	Oral health assessment by a licensed health professional other than a dentist	N/A
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.

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
E1 NCCI associated	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 NCCI associated	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 NCCI associated	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 NCCI associated	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).	N/A
ET	Emergency services	N/A
F1 NCCI associated	Left hand, second digit	N/A
F2 NCCI associated	Left hand, third digit	N/A
F3 NCCI associated	Left hand, fourth digit	N/A
F4 NCCI associated	Left hand, fifth digit	N/A
F5 NCCI associated	Right hand, thumb	N/A

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
F6 NCCI associated	Right hand, second digit	N/A
F7 NCCI associated	Right hand, third digit	N/A
F8 NCCI associated	Right hand, fourth digit	N/A
F9 NCCI associated	Right hand, fifth digit	N/A
FA NCCI associated	Left hand, thumb	N/A
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 99241 thru 99245 + FP 99281 thru 99285 + FP 99341 thru 99353 + FP 99384 + FP 99394 + FP

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
GC	Physician services provided by a resident and teaching physician	Add modifier to CPT codes ‹‹99202›› thru 99499 (Evaluation and Management Services) as appropriate.
GN	Service delivered under an outpatient speech-language pathology plan of care	Used by LEA to denote licensed speech-language pathologists and 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 registered 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.
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

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
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 to denote that the patient is a child.
HB	Adult program, nongeriatric	Used by adult subacute facility to denote that the patient is an adult.
HD	Pregnant/parenting women's program	Used when billing for either a positive or negative depression screening for pregnant or postpartum recipients.
HM	Less than bachelor degree level	Used to denote that the rendering provider is certified as a Sign Language Interpreter.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
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.
‹‹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››
KC	Replacement of special power wheelchair interface	N/A

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
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 NCCI associated	Left circumflex coronary artery	N/A
LD NCCI associated	Left anterior descending coronary artery	N/A
LM †	Left main coronary artery	N/A
LT NCCI associated	Left side (used to identify procedures performed on the left side of the body)	N/A
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	N/A
MB	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access	N/A

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
MC	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	N/A
MD	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances	N/A
ME	The order for this service adheres to appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional	N/A
MF	The order for this service does not adhere to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional	N/A
MG	The order for this service does not have applicable appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional	N/A
MH	Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider	N/A

‹‹**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.
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.
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.
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 NCCI associated	Right coronary artery	N/A
RI †	Ramus intermedius	N/A
RR	Rental	Used to indicate when DME is to be rented.
RT NCCI associated	Right side (used to identify procedures performed on the right side of the body)	N/A
SA	Nurse practitioner rendering service in collaboration with a physician	N/A
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	N/A
SE	State and/or federally funded programs/services	N/A
SK	Member of high-risk population (use only with codes for immunization)	N/A
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 NCCI associated	Left foot, second digit	N/A
T2 NCCI associated	Left foot, third digit	N/A
T3 NCCI associated	Left foot, fourth digit	N/A
T4 NCCI associated	Left foot, fifth digit	N/A
T5 NCCI associated	Right foot, great toe	N/A
T6 NCCI associated	Right foot, second digit	N/A
T7 NCCI associated	Right foot, third digit	N/A
T8 NCCI associated	Right foot, fourth digit	N/A
T9 NCCI associated	Right foot, fifth digit	N/A

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
TA NCCI associated	Left foot, great toe	N/A
TC	Technical component	N/A
TD	Registered nurse (RN)	N/A
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 by Pediatric Palliative Care Waiver Program (PPCWP) 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 IFSP. See *Local Educational Agency (LEA)* in the appropriate Part 2 manual for more information.
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.

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
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.
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). See the *Family Planning* section in the appropriate Part 2 manual or the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual for details.
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. Also used with HCPCS code A4269 to indicate the type of spermicide (suppository). 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**
U3	Medicaid level of care 3, 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 (vaginal film). See the *Family Planning* section in the appropriate Part 2 manual or the Family PACT PPBI manual for details.
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.
U5	Medicaid level of care 5, as defined by each state	Used with HCPCS code J3490 to indicate emergency contraceptive pills (ulipristal acetate). 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).
U8	Medicaid level of care 8, as defined by each state	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).
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.

‹‹**Table of Approved Modifiers (continued)**››

Approved Modifier	**National Modifier Description**	**Program-Specific Use of the Modifier and Special Considerations**
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.
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.

Table of Approved Modifiers (continued)

Approved Modifier	National Modifier Description	Program-Specific Use of the Modifier and Special Considerations
US	Six or more patients served	Used to indicate that six or more patients were served in medical transportation.
‹‹V4	Demonstration modifier 4	N/A››
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 NCCI Associated	Separate encounter: a service that is distinct because it occurred during a separate encounter	N/A
XP NCCI Associated	Separate practitioner: a service that is distinct because it was performed by a different practitioner	N/A
XS NCCI Associated	Separate structure: a service that is distinct because it was performed on a separate organ/structure	N/A
XU NCCI Associated	Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service	N/A

‹‹**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.
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››

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	AIDS Waiver providers only. Administrative expenses when billed by Computer Media Claims (CMC).
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**››

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