

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Effective Date: 03/01/11
Section: General Coding Information	Section: 81.02 Pages: 14 Cross Reference: Ambulance 8.0 Durable Medical Equipment 10.0; Community Mental Health Centers 15.0; Community-Based Mental Health Services 21.0; Maternity 38.0; Radiology 46.0; Anesthesia 51.0; Surgery 52.0; Physician 55.0; HCBS/Elderly & Disabled Waiver 65.0; HCBS/Independent Living Waiver 66.0; HCBS/ Intellectual Disabilities/ Developmental Disabilities Waiver 16.0 HCBS/Assisted Living Waiver 68.0; HCBS/Traumatic Brain Injury/Spinal Cord Injury Waiver 69.0;	
Subject: Modifiers		

A modifier is a numeric or alphanumeric character that is reported with Healthcare Common Procedure Coding System (HCPCS) codes, when appropriate. Modifiers provide payer sources with additional information for a claim. A modifier provides the means by which a provider can report a service or procedure was altered by some specific circumstance. Use of a modifier does not change the definition of the code. While modifiers are valuable in the reporting of services, uses of modifiers do not guarantee reimbursement.

Modifiers are applicable nationally for Medicare, Medicaid, and other insurance carriers. The Division of Medicaid (DOM) accepts all modifiers in accordance with HIPAA standards; however, DOM only requires and utilizes certain modifiers to guide reimbursement or to capture data. On the subsequent pages, Tables A, B, and C identify those utilized by DOM.

There are two levels of modifiers within the HCPCS coding system.

- Level I or CPT modifiers are 2 digit numeric or alphanumeric characters developed by the *American Medical Association (AMA)*. Refer to Table A for a listing of Level I modifiers that are utilized by DOM.
- Level II or HCPCS modifiers are 2 digit alpha or alphanumeric characters developed by the Centers for Medicare and Medicaid Services (CMS) as an adjunct coding system to the AMA Current Procedural Terminology (CPT) code sets. Refer to Table B for a listing of Level II modifiers that are utilized by DOM.

DOM also requires that ambulance providers use ambulance HCPCS modifiers to report the pickup origin and destination location. Refer to Table C for a listing of Level II Ambulance HCPCS modifiers that are utilized by the Mississippi Medicaid Program.

Some common reasons for using modifiers include, but are not limited to, the following:

- A service or procedure had a professional and technical component.
- A procedure(s) was performed by multiple physicians (Ex: assistant surgeon, co-surgeon, team surgeon).
- Only part of a service was performed.
- A bilateral procedure was performed.
- Multiple surgical procedures were performed.
- Identification of a specific site.
- To identify whether equipment being purchased or rented.

-
-
-
- Origin/destination for ambulance services

Documentation Requirements

Careful documentation in medical records is essential in supporting coding with modifiers. Medical records must be complete and describe the modified or altered circumstances which justify use of a modifier with a code. Providers utilizing modifiers on claims should be knowledgeable of the correct usage, the documentation requirements, and DOM policies relating to use of modifiers. Providers should review each claim carefully prior to submission to ensure that documentation, if requested, can support use of the modifiers. In addition, all DOM documentation policies throughout the Provider Policy Manual may also apply to use of modifiers.

Table A
Level I (CPT) Modifiers

Modifier	Description	Correct Application	Impact On Reimbursement
26	Professional Component	Use to identify the professional component of a physician service which is being reported separately.	Directs claim to fee schedule for professional components.
50	Bilateral Procedure	Use to report exact procedures that are performed at the same operative session by the same physician on anatomically bilateral sides of the body identified by the same CPT code. (Refer to Section 52.04).	Refer to Section 52.04 for reimbursement policy.
51	Multiple Procedures	Use to identify secondary surgeries. (Refer to appropriate policies in Sections 52.02 through 52.11).	Refer to Section 52.03 for reimbursement policy.
54	Surgical Care only	Use when one physician performs a surgical procedure and another provides preoperative and/or postoperative management. (Refer to Section 52.13).	Refer to Section 52.13 for reimbursement policy.
55	Postoperative Management	Use when one physician performed the postoperative management and another physician performed the surgical procedure. (Refer to Section 52.13).	Refer to Section 52.13 for reimbursement policy.
56	Preoperative Management	Use when one physician performed the preoperative care and evaluation and another physician/practitioner performed the surgical procedure. (Refer to Section 52.13).	Refer to Section 52.13 for reimbursement policy. Surgical codes billed with modifier 56 will be denied.
62	Two Surgeons (Co-surgery)	Use when two surgeons (usually different specialties) work together as primary surgeons performing distinct parts(s) of a single procedure simultaneously. (Refer to Sections 52.08).	Refer to Section 52.08 for reimbursement policy.

Modifier	Description	Correct Application	Impact On Reimbursement
66	Surgical Team	Use when a team of surgeons (more than two (2) surgeons of different specialties) are required to perform specifically different procedures simultaneously. (Refer to Section 52.09).	Refer to Section 52.09 for reimbursement policy.
80	Assistant Surgeon	Use when a licensed physician actively assists the physician in charge of a case in performing a surgical procedure. (Refer to Section 52.07).	Refer to Section 52.07 for reimbursement policy.

Table B
Level II (HCPCS) Modifiers

Modifier	Description	Correct Application	Impact On Reimbursement
AA	Anesthesia performed by anesthesiologist	Use to identify that service was personally performed by anesthesiologist. (Refer to Section 51.02)	Directs claim to allow 100% of the Medicaid allowance for the physician service.
AH	Clinical Psychologist	Use in 2 nd modifier field to identify services performed by a clinical psychologist for Community-Based Mental Health Services. (Refer to Section 21.02).	Used for data collection and tracking.
AJ	Clinical Social Worker	Use in 2 nd modifier field to identify services performed by a clinical social worker for Community-Based Mental Health Services. (Refer to Section 21.02).	Used for data collection and tracking.
EP	Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) services	Use with all Mississippi Cool Kids Program (EPSDT) Screening codes. Use on all codes billed by a school provider. PHRM/ISS providers must use when billing for infant in-home nurse services. Vaccines for Children Program providers must use when billing either a vaccine code(s) and/or administration code(s).	Used for data collection and tracking. Used to direct claim to pricing file for services by a school provider. Directs claims for appropriate pricing. Vaccine codes: Used for data collection and tracking. Administration codes: Directs claim to VFC fee schedule for pricing administration of vaccines.

Modifier	Description	Correct Application	Impact On Reimbursement
FP	Services part of Family Planning Program	Use to identify all family planning services in both the non-waiver and waiver programs.	Used for data collection and tracking.
GC	This service has been performed in part by a resident under the direction of a teaching physician.	Use to identify that the anesthesiologist assumed full responsibility for the patient while the anesthesia was being administered by a resident in a teaching facility. (Refer to Sections 51.02 and 51.04).	Used for data collection and tracking.
GK	MYPAC Waiver: Statutorily Excluded: Acute respite services	Use in the 2 nd modifier field for respite days 1 through 3 (or less) or respite days 15 through 29 provided in an acute psychiatric hospital (Code H0045).	Days 1 through 3 and days 15 through 29 will be zero paid.
GT	Via interactive audio and video telecommunication systems	Use to identify teleradiology services. (Refer to Section 46.06).	Used for data collection and tracking.
GY	MYPAC Waiver: Statutorily Excluded	Use in the 2 nd modifier field for respite days 1 through 9 (or less) or respite days 20 through 29 (or less) provided in a PRTF (Code H0045).	Days 1 through 9 and days 20 through 29 will be zero paid.
HA	Child/Adolescent Program	Use in 2 nd modifier field to bill certain services provided by Community Mental Health Centers (Refer to Section 15.30). Use in the 1 st modifier field to identify expanded EPSDT Mental Health Services for Community Based Mental Health Services. (Refer to section 21.0).	Used for data collection and tracking.

Modifier	Description	Correct Application	Impact On Reimbursement
HB	Adult program, non-geriatric	Use in the 2 nd modifier field to bill certain services provided by Community Mental Health Center (Refer to section 15.30).	Used for data collection and tracking.
HC	Adult program, geriatric	Use in the 2 nd modifier field to bill certain services provided by Community Mental Health Centers (Refer to Section 15.30).	Used for data collection and tracking.
HE	Level II for MI (Community Mental Health Center)	Use when Level II PASRR Evaluation for Mental illness (MI) is conducted by a Community Mental Health Center.	Directs claims for appropriate pricing.
HI	Level II for MR (Regional Center)	Use when Level II PASRR Evaluation for Mental Retardation (MR) is conducted by a Regional Center.	Directs claims for appropriate pricing.
HK	MYPAC Waiver: Special High Risk Mental Health Population	Use in 1 st modifier field for <u>all</u> MYPAC waiver services (Codes T2022, H2022, or H0045) provided by a MYPAC provider.	Directs claim to fee schedule for pricing of MYPAC Waiver services.
HN	Bachelors degree level	Use in 2 nd modifier field with procedure code H2019 to identify that the ID/DD Waiver service was provided by a Bachelor's level provider.	Used to direct the claim for correct pricing for the service under the ID/DD Waiver.
HO	Masters degree level	Use in the 2 nd modifier field with procedure code H2019 to identify that the ID/DD service was provided by a Master's level provider.	Used to direct the claim for correct pricing under the ID/DD Waiver.
HT	Multi-disciplinary team	Use in 2 nd modifier field to report certain services provided by Community Mental Health Centers (Refer to Section 15.30).	Used for data collection and tracking.

Modifier	Description	Correct Application	Impact On Reimbursement
HW	State mental health agency funded	Use in 1 st modifier field to report all services billed by Community Mental Health Centers.	For reporting purposes for the correct collection of match from Department of Mental Health.
KR	Rental item, billing for partial month, Daily DME rental	Use to identify DME rental for a partial month. (Refer to Section 10.02).	Directs claim to DME fee schedule for daily rental of durable medical equipment.
LT	Left side	Use to indicate a procedure was performed on left side of body.	Used for data collection and tracking.
NU	New Durable Medical Equipment	Use to report purchasing of new durable medical equipment. (Refer to Section 10.02).	Directs claims to DME fee schedule for pricing of new durable medical equipment.
Q5	Service furnished by a substitute physician/practitioner under a reciprocal billing arrangement	Use when a regular physician or group has a substitute physician provide covered services to a Medicaid beneficiary on an occasional reciprocal basis. (Refer to Section 55.09).	Used for data collection and tracking.
Q6	Service furnished by a locum tenens physician	Use when the patient's regular physician retains a substitute physician to take over his/her practice during an absence. (Refer to Section 55.09).	Used for data collection and tracking.
QW	CLIA waived test	Use to identify tests authorized by CLIA to be performed by the holder of Waiver Certificates.	Used for data collection and tracking.
QX	CRNA service with MD medical direction	Use on both, the CRNA claim and the physician claim, to identify that CRNA performed service with medical direction by a physician. (Refer to sections 51.02 and 51.03).	Refer to section 51.03 for reimbursement policy.

Modifier	Description	Correct Application	Impact On Reimbursement
QZ	CRNA service without medical direction by MD	Use to identify CRNA service performed without medical direction by physician. (Refer to sections 51.02 and 51.03).	Refer to section 51.03 for reimbursement policy.
RP	Replacement and repair (DME)	Use when billing for repairs for durable medical equipment, orthotics, or prosthetics. (Refer to section 10.02).	Directs claim for appropriate pricing.
RR	Monthly DME Rental	Use to identify DME rented for a full month. (Refer to Section 10.02).	Directs claim to DME fee schedule for monthly rental of durable medical equipment.
RT	Right Side	Use to indicate a procedure was performed on right side of body.	Used for data collection and tracking.
SC	Medically necessary service or supply	Use to identify a medical supplies billed by DME supplier through DME program. (Refer to Section 10.02).	Directs the claim to the DME fee schedule for medical supplies.
SD	Services provided by registered nurse with specialized, highly technical home infusion training	Use to identify home infusion nurse services which have been prior authorized by DOM.	Directs claim to correct pricing for home infusion nurse services.
TA	Left foot, great toe	Use to indicate a procedure was performed on the great toe of the left foot.	Used for data collection and tracking.
TC	Technical Component	Use to identify the technical component of a procedure is being reported separately.	Directs claim to fee schedule for technical components.
TF	MYPAC Waiver: Statutorily Excluded	Use in the 2 nd modifier field for respite days 10 through 19 (or less) provided in a PRTF (Code H0045)	Days 10 through 19 will be paid at the MYPAC provider's per diem rate.
	ID/DD Waiver: Immediate level of care	Use in 2 nd modifier field when billing T2022 Support Coordination 2 nd level payment for ID/DD Waiver.	Directs claim to correct pricing file.

Modifier	Description	Correct Application	Impact on Reimbursement
TG	Complex High Level of Care	Use in the 2nd modifier field for respite days 4 through 14 (or less) provided in an acute psychiatric hospital (Code H0045) when used for MYPAC Waiver services. EPSDT- Use to report RN or L.P.N _Private Duty Nursing (PDN) services provided to Mississippi Medicaid beneficiary on home ventilation.	Days 4 through 14 will be paid at the MYPAC provider's per diem rate. Directs claim to pricing file for PDN for ventilation patients.
TH	OB treatment/ services, prenatal/ postpartum	Use to identify all maternity services. (Refer to Sections 38.05 and 51.05). Use to identify physician services for normal well-baby. (Bill on baby's own Medicaid ID number with appropriate CPT code and modifier –TH)	Used to bypass physician visit limitation of twelve (12) visits per fiscal year and for data collection and tracking. Used for data collection and tracking and to bypass TAN requirement on physician claim for normal (well baby) newborn.
TL	Early Intervention IFSP	Use with code T1017 to identify Early Intervention targeted case management.	Directs claim to pricing file for this Early Intervention service.
T1	Left foot, second digit	Use to indicate a procedure was performed on the second digit of the left foot.	Used for data collection and tracking.
T2	Left foot, third digit	Use to indicate a procedure was performed on the third digit of the left foot.	Used for data collection and tracking.
T3	Left foot, fourth digit	Use to indicate a procedure was performed on the fourth digit of the left foot.	Used for data collection and tracking.
T4	Left foot, fifth digit	Use to indicate a procedure was performed on the fifth digit of the left foot.	Used for data collection and tracking.

Modifier	Description	Correct Application	Impact on Reimbursement
T5	Right foot, Great toe	Use to indicate a procedure was performed on the great toe of the right foot.	Used for data collection and tracking.
T6	Right foot, second digit	Use to indicate a procedure was performed on the second digit of the right foot.	Used for data collection and tracking.
T7	Right foot, third digit	Use to indicate a procedure was performed on the third digit of the right foot.	Used for data collection and tracking.
T8	Right foot, fourth digit	Use to indicate a procedure was performed on the fourth digit of the right foot.	Used for data collection and tracking.
T9	Right foot, fifth digit	Use to indicate a procedure was performed on the fifth digit of the right foot.	Used for data collection and tracking.
U1	HCBS/Elderly & Disabled Waiver.	Use in 1 st modifier field to identify all HCBS/Elderly & Disabled Waiver services. (Refer to Section 65.11).	Refer to Section 65.11 for reimbursement policy.
U2	HCBS/Independent Living Waiver.	Use in 1 st modifier field to identify all HCBS/Independent Living Waiver services. (Refer to Section 66.10).	Used for reporting purposes for the correct collection of match from the Mississippi Department of Rehabilitation Services. Refer to Section 66.10 for reimbursement policy.
U3	HCBS/ Intellectual Disabilities/Developmental Disabilities Waiver	Use in 1 st modifier field to identify all HCBS/ Intellectual Disabilities/Developmental Disabilities Waiver services.	Used for reporting purposes for the correct collection of match from the Department of Mental Health.

Modifier	Description	Correct Application	Impact On Reimbursement
U4	HCBS/Assisted Living Waiver.	Use in 1 st modifier field to identify all HCBS/Assisted Living Waiver services. (Refer to section 68.10).	Refer to Section 68.10 for reimbursement policy.
U5	HCBS/Traumatic Brain Injury/Spinal Cord Injury Waiver.	Use in 1 st modifier field to identify all HCBS/Traumatic Brain Injury/Spinal Cord Injury Waiver services. (Refer to Section 69.10).	Used for reporting purposes for the correct collection of match from the Mississippi Department of rehabilitation Services. Refer to Section 69.10 for reimbursement policy.
UE	Used Durable Medical Equipment	Use to report purchase of used durable medical equipment. Refer to section 10.02.	Directs claim to DME fee schedule for purchase of durable medical equipment.

Table C**Ambulance HCPCS Modifiers**

Modifier	Description	Correct Application	Impact on Reimbursement
D	Diagnostic or therapeutic other than the physician's office or hospital when these codes are used as origin codes.	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
E	Residential, domiciliary, custodial facility	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
G	Hospital based dialysis facility (hospital or hospital-related)	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
H	Hospital	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
I	Site of transfer (e.g, airport or helicopter pad) between types of ambulances	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
J	Non-hospital based dialysis facility	Use to identify the place of origin or destination during an ambulance transport. (Refer to section 8.12).	Used for data collection and tracking.
N	Skilled nursing facility	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
P	Physician's office (includes health maintenance organization, ASC hospital facility, clinic, etc.)	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.

Modifier	Description	Correct Application	Impact on Reimbursement
R	Residence	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
S	Scene of accident or acute event	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
X	(Destination code only) Intermediate stop at physician's office on the way to the hospital (includes health maintenance organization, ASC, hospital facility, clinic, etc.)	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: X Current:	<u>Effective Date:</u> <u>01/01/08</u> <u>03/01/11</u>
Section: General Coding Information	Section: 81.02 Pages: 14	
Subject: Modifiers	Cross Reference: Ambulance 8.0 Durable Medical Equipment 10.0; Community Mental Health Centers 15.0; Community-Based Mental Health Services 21.0; Maternity 38.0; Radiology 46.0; Anesthesia 51.0; Surgery 52.0; Physician 55.0; HCBS/Elderly & Disabled Waiver 65.0; HCBS/Independent Living Waiver 66.0; HCBS/Mentally Retarded Developmentally Disabled Waiver 67.0; HCBS/ Intellectual Disabilities/ Developmental Disabilities Waiver 16.0 HCBS/Assisted Living Waiver 68.0; HCBS/Traumatic Brain Injury/Spinal Cord Injury Waiver 69.0;	

A modifier is a numeric or alphanumeric character that is reported with Healthcare Common Procedure Coding System (HCPCS) codes, when appropriate. Modifiers provide payer sources with additional information for a claim. A modifier provides the means by which a provider can report a service or procedure was altered by some specific circumstance. Use of a modifier does not change the definition of the code. While modifiers are valuable in the reporting of services, uses of modifiers do not guarantee reimbursement.

Modifiers are applicable nationally for Medicare, Medicaid, and other insurance carriers. The Division of Medicaid (DOM) accepts all modifiers in accordance with HIPAA standards; however, DOM only requires and utilizes certain modifiers to guide reimbursement or to capture data. On the subsequent pages, Tables A, B, and C identify those utilized by DOM.

There are two levels of modifiers within the HCPCS coding system.

- Level I or CPT modifiers are 2 digit numeric or alphanumeric characters developed by the *American Medical Association (AMA)*. Refer to Table A for a listing of Level I modifiers that are utilized by DOM.
- Level II or HCPCS modifiers are 2 digit alpha or alphanumeric characters developed by the Centers for Medicare and Medicaid Services (CMS) as an adjunct coding system to the AMA Current Procedural Terminology (CPT) code sets. Refer to Table B for a listing of Level II modifiers that are utilized by DOM.

DOM also requires that ambulance providers use ambulance HCPCS modifiers to report the pickup origin and destination location. Refer to Table C for a listing of Level II Ambulance HCPCS modifiers that are utilized by the Mississippi Medicaid Program.

Some common reasons for using modifiers include, but are not limited to, the following:

- A service or procedure had a professional and technical component.
- A procedure(s) was performed by multiple physicians (Ex: assistant surgeon, co-surgeon, team surgeon).
- Only part of a service was performed.
- A bilateral procedure was performed.
- Multiple surgical procedures were performed.
- Identification of a specific site.

-
-
- To identify whether equipment being purchased or rented.
 - Origin/destination for ambulance services

Documentation Requirements

Careful documentation in medical records is essential in supporting coding with modifiers. Medical records must be complete and describe the modified or altered circumstances which justify use of a modifier with a code. Providers utilizing modifiers on claims should be knowledgeable of the correct usage, the documentation requirements, and DOM policies relating to use of modifiers. Providers should review each claim carefully prior to submission to ensure that documentation, if requested, can support use of the modifiers. In addition, all DOM documentation policies throughout the Provider Policy Manual may also apply to use of modifiers.

Table A
Level I (CPT) Modifiers

Modifier	Description	Correct Application	Impact On Reimbursement
26	Professional Component	Use to identify the professional component of a physician service which is being reported separately.	Directs claim to fee schedule for professional components.
50	Bilateral Procedure	Use to report exact procedures that are performed at the same operative session by the same physician on anatomically bilateral sides of the body identified by the same CPT code. (Refer to Section 52.04).	Refer to Section 52.04 for reimbursement policy.
51	Multiple Procedures	Use to identify secondary surgeries. (Refer to appropriate policies in Sections 52.02 through 52.11).	Refer to Section 52.03 for reimbursement policy.
54	Surgical Care only	Use when one physician performs a surgical procedure and another provides preoperative and/or postoperative management. (Refer to Section 52.13).	Refer to Section 52.13 for reimbursement policy.
55	Postoperative Management	Use when one physician performed the postoperative management and another physician performed the surgical procedure. (Refer to Section 52.13).	Refer to Section 52.13 for reimbursement policy.
56	Preoperative Management	Use when one physician performed the preoperative care and evaluation and another physician/practitioner performed the surgical procedure. (Refer to Section 52.13).	Refer to Section 52.13 for reimbursement policy. Surgical codes billed with modifier 56 will be denied.
62	Two Surgeons (Co-surgery)	Use when two surgeons (usually different specialties) work together as primary surgeons performing distinct parts(s) of a single procedure simultaneously. (Refer to Sections 52.08).	Refer to Section 52.08 for reimbursement policy.

Modifier	Description	Correct Application	Impact On Reimbursement
66	Surgical Team	Use when a team of surgeons (more than two (2) surgeons of different specialties) are required to perform specifically different procedures simultaneously. (Refer to Section 52.09).	Refer to Section 52.09 for reimbursement policy.
80	Assistant Surgeon	Use when a licensed physician actively assists the physician in charge of a case in performing a surgical procedure. (Refer to Section 52.07).	Refer to Section 52.07 for reimbursement policy.

Table B
Level II (HCPCS) Modifiers

Modifier	Description	Correct Application	Impact On Reimbursement
AA	Anesthesia performed by anesthesiologist	Use to identify that service was personally performed by anesthesiologist. (Refer to Section 51.02)	Directs claim to allow 100% of the Medicaid allowance for the physician service.
AH	Clinical Psychologist	Use in 2 nd modifier field to identify services performed by a clinical psychologist for Community-Based Mental Health Services. (Refer to Section 21.02).	Used for data collection and tracking.
AJ	Clinical Social Worker	Use in 2 nd modifier field to identify services performed by a clinical social worker for Community-Based Mental Health Services. (Refer to Section 21.02).	Used for data collection and tracking.
EP	Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) services	Use with all Mississippi Cool Kids Program (EPSDT) Screening codes. Use on all codes billed by a school provider. Use on codes for private duty nursing (PDN) services except for PDN services beneficiaries on home ventilator (Refer to modifier TG). <u>PHRM/ISS providers must use when billing for infant in-home nurse services.</u> Vaccines for Children Program providers must use when billing either a vaccine code(s) and/or administration code(s).	Used for data collection and tracking. Used to direct claim to pricing file for services by a school provider. Used for data collection and tracking. <u>Directs claims for appropriate pricing.</u> Vaccine codes: Used for data collection and tracking. Administration codes: Directs claim to VFC fee schedule for pricing administration of vaccines.

Modifier	Description	Correct Application	Impact On Reimbursement
FP	Services part of Family Planning Program	Use to identify all family planning services in both the non-waiver and waiver programs.	Used for data collection and tracking.
GC	This service has been performed in part by a resident under the direction of a teaching physician.	Use to identify that the anesthesiologist assumed full responsibility for the patient while the anesthesia was being administered by a resident in a teaching facility. (Refer to Sections 51.02 and 51.04).	Used for data collection and tracking.
GK	MYPAC Waiver: Statutorily Excluded: Acute respite services	Use in the 2 nd modifier field for respite days 1 through 3 (or less) or respite days 15 through 29 provided in an acute psychiatric hospital (Code H0045).	Days 1 through 3 and days 15 through 29 will be zero paid.
GT	Via interactive audio and video telecommunication systems	Use to identify teleradiology services. (Refer to Section 46.06).	Used for data collection and tracking.
GY	MYPAC Waiver: Statutorily Excluded	Use in the 2 nd modifier field for respite days 1 through 9 (or less) or respite days 20 through 29 (or less) provided in a PRTF (Code H0045).	Days 1 through 9 and days 20 through 29 will be zero paid.
HA	Child/Adolescent Program	Use in 2nd modifier field to bill certain services provided by Community Mental Health Centers (Refer to Section 15.30). Use in the 1st modifier field to identify expanded EPSDT Mental Health Services for Community Based Mental Health Services. (Refer to section 21.0).	Used for data collection and tracking.

Modifier	Description	Correct Application	Impact On Reimbursement
HB	Adult program, non-geriatric	Use in the 2 nd modifier field to bill certain services provided by Community Mental Health Center (Refer to section 15.30).	Used for data collection and tracking.
HC	Adult program, geriatric	Use in the 2 nd modifier field to bill certain services provided by Community Mental Health Centers (Refer to Section 15.30).	Used for data collection and tracking.
<u>HE</u>	<u>Level II for MI (Community Mental Health Center)</u>	<u>Use when Level II PASRR Evaluation for Mental illness (MI) is conducted by a Community Mental Health Center.</u>	<u>Directs claims for appropriate pricing.</u>
<u>HI</u>	<u>Level II for MR (Regional Center)</u>	<u>Use when Level II PASRR Evaluation for Mental Retardation (MR) is conducted by a Regional Center.</u>	<u>Directs claims for appropriate pricing.</u>
HK	MYPAC Waiver: Special High Risk Mental Health Population	Use in 1 st modifier field for <u>all</u> MYPAC waiver services (Codes T2022, H2022, or H0045) provided by a MYPAC provider.	Directs claim to fee schedule for pricing of MYPAC Waiver services.
HN	Bachelors degree level	Use in 2 nd modifier field with procedure code H2019 to identify that the MR/DD ID/DD Waiver service was provided by a Bachelor's level provider (Refer to Section 67.10).	Used to direct the claim for correct pricing for the service under the MR/DD ID/DD Waiver.
HO	Masters degree level	Use in the 2 nd modifier field with procedure code H2019 to identify that the MR/DD ID/DD service was provided by a Master's level provider. (Refer to Section 67.10).	Used to direct the claim for correct pricing under the MR/DD ID/DD Waiver.
HT	Multi-disciplinary team	Use in 2 nd modifier field to report certain services provided by Community Mental Health Centers (Refer to Section 15.30).	Used for data collection and tracking.

Modifier	Description	Correct Application	Impact On Reimbursement
HW	State mental health agency funded	Use in 1 st modifier field to report all services billed by Community Mental Health Centers.	For reporting purposes for the correct collection of match from Department of Mental Health.
KR	Rental item, billing for partial month, Daily DME rental	Use to identify DME rental for a partial month. (Refer to Section 10.02).	Directs claim to DME fee schedule for daily rental of durable medical equipment.
LT	Left side	Use to indicate a procedure was performed on left side of body.	Used for data collection and tracking.
NU	New Durable Medical Equipment	Use to report purchasing of new durable medical equipment. (Refer to Section 10.02).	Directs claims to DME fee schedule for pricing of new durable medical equipment.
Q5	Service furnished by a substitute physician/practitioner under a reciprocal billing arrangement	Use when a regular physician or group has a substitute physician provide covered services to a Medicaid beneficiary on an occasional reciprocal basis. (Refer to Section 55.09).	Used for data collection and tracking.
Q6	Service furnished by a locum tenens physician	Use when the patient's regular physician retains a substitute physician to take over his/her practice during an absence. (Refer to Section 55.09).	Used for data collection and tracking.
QW	CLIA waived test	Use to identify tests authorized by CLIA to be performed by the holder of Waiver Certificates.	Used for data collection and tracking.
QX	CRNA service with MD medical direction	Use on both, the CRNA claim and the physician claim, to identify that CRNA performed service with medical direction by a physician. (Refer to sections 51.02 and 51.03).	Refer to section 51.03 for reimbursement policy.

Modifier	Description	Correct Application	Impact On Reimbursement
QZ	CRNA service without medical direction by MD	Use to identify CRNA service performed without medical direction by physician. (Refer to sections 51.02 and 51.03).	Refer to section 51.03 for reimbursement policy.
RP	Replacement and repair (DME)	Use when billing for repairs for durable medical equipment, orthotics, or prosthetics. (Refer to section 10.02).	Directs claim for appropriate pricing.
RR	Monthly DME Rental	Use to identify DME rented for a full month. (Refer to Section 10.02).	Directs claim to DME fee schedule for monthly rental of durable medical equipment.
RT	Right Side	Use to indicate a procedure was performed on right side of body.	Used for data collection and tracking.
SC	Medically necessary service or supply	Use to identify a medical supplies billed by DME supplier through DME program. (Refer to Section 10.02).	Directs the claim to the DME fee schedule for medical supplies.
SD	Services provided by registered nurse with specialized, highly technical home infusion training	Use to identify home infusion nurse services which have been prior authorized by DOM.	Directs claim to correct pricing for home infusion nurse services.
TA	Left foot, great toe	Use to indicate a procedure was performed on the great toe of the left foot.	Used for data collection and tracking.
TC	Technical Component	Use to identify the technical component of a procedure is being reported separately.	Directs claim to fee schedule for technical components.
TF	MYPAC Waiver: Statutorily Excluded	Use in the 2 nd modifier field for respite days 10 through 19 (or less) provided in a PRTF (Code H0045)	Days 10 through 19 will be paid at the MYPAC provider's per diem rate.
	MR/DD Waiver <u>ID/DD Waiver</u> : Immediate level of care	Use in 2 nd modifier field when billing T2022 Support Coordination 2 nd level payment for MR/DD <u>ID/DD</u> Waiver.	Directs claim to correct pricing file.

Modifier	Description	Correct Application	Impact on Reimbursement
TG	Complex High Level of Care	Use in the 2nd modifier field for respite days 4 through 14 (or less) provided in an acute psychiatric hospital (Code H0045) when used for MYPAC Waiver services. EPSDT- Use to report RN <u>or</u> L.P.N Private Duty Nursing (PDN) services provided to Mississippi Medicaid beneficiary on home ventilation.	Days 4 through 14 will be paid at the MYPAC provider's per diem rate. Directs claim to pricing file for PDN for ventilation patients.
TH	OB treatment/ services, prenatal/ postpartum	Use to identify all maternity services. (Refer to Sections 38.05 and 51.05). Use to identify physician services for normal well-baby. (Bill on baby's own Medicaid ID number with appropriate CPT code and modifier –TH)	Used to bypass physician visit limitation of twelve (12) visits per fiscal year and for data collection and tracking. Used for data collection and tracking and to bypass TAN requirement on physician claim for normal (well baby) newborn.
TL	Early Intervention IFSP	Use with code T1017 to identify Early Intervention targeted case management.	Directs claim to pricing file for this Early Intervention service.
T1	Left foot, second digit	Use to indicate a procedure was performed on the second digit of the left foot.	Used for data collection and tracking.
T2	Left foot, third digit	Use to indicate a procedure was performed on the third digit of the left foot.	Used for data collection and tracking.
T3	Left foot, fourth digit	Use to indicate a procedure was performed on the fourth digit of the left foot.	Used for data collection and tracking.
T4	Left foot, fifth digit	Use to indicate a procedure was performed on the fifth digit of the left foot.	Used for data collection and tracking.

Modifier	Description	Correct Application	Impact On Reimbursement
T5	Right foot, Great toe	Use to indicate a procedure was performed on the great toe of the right foot.	Used for data collection and tracking.
T6	Right foot, second digit	Use to indicate a procedure was performed on the second digit of the right foot.	Used for data collection and tracking.
T7	Right foot, third digit	Use to indicate a procedure was performed on the third digit of the right foot.	Used for data collection and tracking.
T8	Right foot, fourth digit	Use to indicate a procedure was performed on the fourth digit of the right foot.	Used for data collection and tracking.
T9	Right foot, fifth digit	Use to indicate a procedure was performed on the fifth digit of the right foot.	Used for data collection and tracking.
U1	HCBS/Elderly & Disabled Waiver.	Use in 1 st modifier field to identify all HCBS/Elderly & Disabled Waiver services. (Refer to Section 65.11).	Refer to Section 65.11 for reimbursement policy.
U2	HCBS/Independent Living Waiver.	Use in 1 st modifier field to identify all HCBS/Independent Living Waiver services. (Refer to Section 66.10).	Used for reporting purposes for the correct collection of match from the Mississippi Department of Rehabilitation Services. Refer to Section 66.10 for reimbursement policy.
U3	HCBS/Mentally Retarded Developmentally Disabled Waiver. <u>HCBS/ Intellectual Disabilities/Developmental Disabilities Waiver</u>	Use in 1 st modifier field to identify all HCBS/Mentally Retarded Developmentally Disabled <u>HCBS/ Intellectual Disabilities/Developmental Disabilities</u> Waiver services. (Refer to Section 67.10).	Used for reporting purposes for the correct collection of match from the Department of Mental Health. Refer to Section 67.10 for reimbursement policy.

Modifier	Description	Correct Application	Impact On Reimbursement
U4	HCBS/Assisted Living Waiver.	Use in 1 st modifier field to identify all HCBS/Assisted Living Waiver services. (Refer to section 68.10).	Refer to Section 68.10 for reimbursement policy.
U5	HCBS/Traumatic Brain Injury/Spinal Cord Injury Waiver.	Use in 1 st modifier field to identify all HCBS/Traumatic Brain Injury/Spinal Cord Injury Waiver services. (Refer to Section 69.10).	Used for reporting purposes for the correct collection of match from the Mississippi Department of rehabilitation Services. Refer to Section 69.10 for reimbursement policy.
UE	Used Durable Medical Equipment	Use to report purchase of used durable medical equipment. Refer to section 10.02.	Directs claim to DME fee schedule for purchase of durable medical equipment.

Table C
Ambulance HCPCS Modifiers

Modifier	Description	Correct Application	Impact on Reimbursement
D	Diagnostic or therapeutic other than the physician's office or hospital when these codes are used as origin codes.	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
E	Residential, domiciliary, custodial facility	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
G	Hospital based dialysis facility (hospital or hospital-related)	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
H	Hospital	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
I	Site of transfer (e.g, airport or helicopter pad) between types of ambulances	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
J	Non-hospital based dialysis facility	Use to identify the place of origin or destination during an ambulance transport. (Refer to section 8.12).	Used for data collection and tracking.
N	Skilled nursing facility	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
P	Physician's office (includes health maintenance organization, ASC hospital facility, clinic, etc.)	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.

Modifier	Description	Correct Application	Impact on Reimbursement
R	Residence	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
S	Scene of accident or acute event	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.
X	(Destination code only) Intermediate stop at physician's office on the way to the hospital (includes health maintenance organization, ASC, hospital facility, clinic, etc.)	Use to identify the place of origin or destination during an ambulance transport. (Refer to Section 8.12).	Used for data collection and tracking.