Coding Modifiers Table

Updated 05/22

The following chart has been developed to assist providers in understanding how the Kansas Medical Assistance Program (KMAP) handles specific modifiers. It is imperative providers understand the importance of using these modifiers correctly. Improper coding could result in a delayed, denied, or incorrect payment for the service(s) submitted.

Under the **Invalid Combination** heading on the chart, modifiers are identified which cannot be billed in combination with the modifier in the first column. For example, a surgeon cannot bill a code with both the 62 (*co-surgeon*) and the 80 (*assistant surgeon*) modifiers on the same detail line. The surgeon can only act as a co-surgeon (62) or an assistant surgeon (80) for a specific surgery. Only one modifier, 62 or 80, can be submitted. Invalid modifier-to-modifier combinations and inappropriate billing of multiple modifiers can result in a denial of the service(s) provided.

Certain processing modifiers have different rates based on a percentage of the base code. Under the **Special Coding Instructions** heading on the chart, these modifiers are identified and their rates as a percentage of the base code are given.

The following files are produced by CMS and provide a basis of payment under Medicare. They are provided to all health care providers and contractors nationally to assure consistent claims processing for CMS.

- To determine the global period of a surgery, refer to the Physician Fee Schedule Relative Value Files. View and download a copy of the Physician Fee Schedule Relative Value file from the CMS website.
- Complete definitions of the PC/TC, Glob Days, and Bilat Surg indicators are available on the CMS website.
- View and download a copy of the Medicare Clinical Diagnostic Laboratory Fee Schedule from the CMS website.
- View and download a copy of the Medicare Durable Medical Equipment, Prosthetics/Orthotics & Supplies Fee Schedule from the CMS website.
- View and download a copy of the List of Waived Tests file from the CMS website.

The KMAP website offers additional information on the use of codes and modifiers.

- On the public website, access the following links.
  - Ambulance Coding Modifiers Table
  - Provider manuals
  - Current coverage and pricing information
- Log on to the secure website.
  - From the Publications tab, click Provider Manuals from the drop-down menu.
  - From the main menu, click Pricing and Limitations for current coverage and pricing information.

Modifier	Invalid Combination	Special Coding Instructions
22		Modifier 22 can be used on any procedure within the Anesthesia, Surgery, Radiology, Laboratory/Pathology, and Medicine series of codes. **However, this modifier should not be used on E&M services.** E&M codes with a modifier 22 will be denied. If modifier 22 is used on any surgical procedure, then it must only be used on surgeries which have a global period of 000, 010, 090, or YYY identified on the Medicare Physician Fee Schedule Relative Value File.
23		Modifier 23 can only be submitted with anesthesia *CPT* codes 00100-01989, 01991, 01992, 01993, 01994, 01997, 01998, and 01999. Anesthesiologists, certified registered nurse anesthetists (CRNAs), or anesthesiologist assistants (AAs) should submit this modifier to indicate a procedure which is normally performed under local anesthesia or with a regional block required general anesthesia.
24		This modifier can be used to indicate that an E&M service or eye exam, which falls within the global period of a major or minor surgery, and which is performed by the surgeon, is unrelated to the surgery. ***Note:*** Although the *CPT* description of modifier 24 reflects "postoperative", this modifier can be submitted for a visit performed the day prior to a major surgery when the visit is unrelated to the surgery. This modifier can only be submitted with E&M and eye exam codes. Documentation in the patient's medical record must support the use of this modifier.
25		It may be necessary to indicate on the day a procedure or service identified by a *CPT* code was performed that the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported. The E&M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E&M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E&M service. ***Note:*** This modifier is not used to report an E&M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E&M services, see modifier 59.
26	50, 62, 66, TC	If billing for the global component (professional & technical) of a procedure, modifiers 26 and TC should not be used. Modifier 26 can only be used by professional providers. It should not be used by a hospital. KMAP uses the Medicare Physician Fee Schedule Relative Value file to determine which procedures are appropriately billed with modifier 26. KMAP uses the PT/TC indicator field on the file as a basis to determine proper usage of modifier 26. The following determination has been made based on the individual indicators. This modifier should not be used on procedures which have a PC/TC indicator equal to 0, 2, 3, 4, 5, 8, and 9 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid that has been assigned one of these indicators will be denied unless Medicaid has instructed differently through provider bulletins and/or manuals. Complete definitions of the PC/TC indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009).
27		Modifier 27 is used to identify multiple outpatient hospital E&M encounters on the same date. **This modifier is not to be used by physician practices. It was created exclusively for hospital outpatient departments.** For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E&M encounters performed in multiple outpatient hospital settings on the same date can be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E&M code(s). This modifier cannot be used for physician reporting of multiple E&M services performed by the same physician on the same date. This modifier is valid for the following *CPT* codes: 92004-92014, 99201-99239, 99281-99299, G0101, G0175, & G0380-G0384.
32		Modifier 32 is no longer valid for Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Use modifier EP where modifier 32 was previously used. Claims billed with modifier 32 will be denied. For further billing/coding instructions, refer to the *KAN Be*

Modifier	Invalid Combination	Special Coding Instructions
32		*Healthy - Early and Periodic Screening, Diagnostic, and Treatment Fee-for-Service Provider Manual*.
47		This modifier should be appended only to the surgical procedure code when applicable. It is not appropriate to use this modifier on anesthesia procedure codes. The anesthesiologist would not use this modifier. Do not report modifier 47 when the physician reports moderate (conscious) sedation.
50	26, LT, RT, TC	KMAP uses the Medicare Physician Fee Schedule Relative Value file to determine which procedures are appropriately billed with modifier 50. KMAP uses the Bilat Surg indicator field on the file as a basis to determine proper usage of modifier 50. The following determinations have been made based on the individual indicators. • This modifier should not be used on procedures which have a Bilat Surg indicator equal to 0, 2, 3 and 9 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid that has been assigned one of these indicators will be denied unless Medicaid has instructed differently through provider bulletins and/or manuals. • This modifier should only be used on procedures which have a Bilat Surg indicator equal to 1 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid that has been assigned this indicator will continue to be processed as normal. Complete definitions of the Bilat Surg indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009). When a procedure is identified as one that can have modifier 50 added to the base code when performed bilaterally, bill the procedure code as a single line item on the claim form with modifier 50 and units of service equal to one. For example, a bilateral tympanostomy must be billed indicating code 69436 50 as one unit. When a code states 'unilateral' or 'bilateral' in the description, do not add modifier 50. In this instance, the base code is billed only once on the claim and the number of units is one. For example, code 58900 is equal to one unit. Physicians who perform facet joint injections on both the right and left sides of one level of the spine must use modifier 50 with the appropriate *CPT* codes when submitting claims. Physicians who perform facet joint injections on multiple levels on the same side of the spine must use the *CPT* add-on codes to represent these additional levels injected, instead of using modifier 50. Facet Joint Injection *CPT* codes are 64490 - 64495. **Modifier 50 is a processing modifier, and the rate is 150% of the base code.**
51		KMAP uses the Medicare Physician Fee Schedule Relative Value file to determine which procedures are appropriately billed with modifier 51. KMAP uses the Mult Proc indicator field on the file as a basis to determine proper usage of modifier 51. The following determinations have been made based on the individual indicators. • This modifier should not be used on procedures which have a Mult Proc indicator equal to 0 and 9 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid that has been assigned one of these indicators will be denied unless Medicaid has instructed differently through bulletins and/or provider manuals. • This modifier should only be used on procedures which have a Mult Proc indicator equal to 1, 2, 3 and 4 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid that has been assigned any of these indicators will continue to be processed as normal. Complete definitions of the Mult Proc indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009). This modifier cannot be submitted with designated add-on codes (refer to the *CPT* codebook for a list of add-on codes). Also, any code with a Glob Surg indicator equal to ZZZ on the Medicare Physician Fee Schedule Relative Value file is considered an add-on code.
52		Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. KMAP does not recognize modifier 52 when used on E&M codes if supporting

Modifier	Invalid Combination	Special Coding Instructions
52		documentation is not submitted to support its use. Do not use this modifier if the procedure is discontinued after administration of anesthesia (use modifier 53).
53		Under certain circumstances, the physician can elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance can be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Modifier 53 should not be used on E&M codes. It is only valid for surgical and medical diagnostic codes when the procedure was started but had to be discontinued because of extenuating circumstances. KMAP denies E&M codes when billed with modifier 53.
54	55, 56, 80, 81, 82, AS	When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical codes can be identified by adding the modifier 54. Physicians who perform the surgery and furnish all of the usual pre- and post-operative work bill for the global package by entering the appropriate *CPT* code for the surgical procedure only; therefore, modifiers 54 and 55 cannot be combined on a single detail line item. KMAP uses the Medicare Physician Fee Schedule Relative Value file to determine which procedures are appropriately billed with modifier 54. KMAP uses the Glob Days field on the file as a basis to determine proper usage of modifier 54. The following determinations have been made based on the individual indicators. • This modifier cannot be used on procedures unless the Glob Days field is equal to 010 or 090 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid with modifier 54 and global surgery days other than 010 and 090 will be denied unless Medicaid has instructed differently through provider bulletins and/or manuals. • This modifier can only be used on procedures which have a Glob Days field equal to 010 or 090 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid and assigned global surgery days equal to 010 or 090 will process as normal. Complete definitions of the Glob Days indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009).
55	54, 56, 78, 80, 81, 82, AS	When one physician performs the postoperative management and another physician performs the surgical procedure, the postoperative component can be identified by adding modifier 55 to the code. Physicians who perform the surgery and furnish all of the usual pre- and post-operative work bill for the global package by entering the appropriate *CPT* code for the surgical procedure only; therefore, modifiers 54 and 55 cannot be combined on a single detail line item. KMAP uses the Medicare Physician Fee Schedule Relative Value file to determine which procedures are appropriately billed with modifier 55. KMAP uses the Glob Days field on the file as a basis to determine proper usage of modifier 55. The following determinations have been made based on the individual indicators. • This modifier cannot be used on procedures unless the Glob Days field is equal to 010 or 090 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid with modifier 55 and global surgery days other than 010 and 090 will be denied unless Medicaid has instructed differently through provider bulletins and/or manuals. • This modifier can only be used on procedures which have a Glob Days field equal to 010 or 090 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid that has been assigned global surgery days equal to 010 or 090 will process as normal. Complete definitions of the Glob Days indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009).
56		When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component can be identified by adding modifier 56 to the code. Physicians who perform the surgery and furnish all of the usual pre- and post-operative work bill for the global package by entering the appropriate *CPT* code for the surgical procedure only. KMAP uses the Medicare Physician Fee Schedule Relative Value file to determine which procedures are appropriately billed with modifier 56.

Modifier	Invalid Combination	Special Coding Instructions
56		KMAP uses the Glob Days field on the file as a basis to determine proper usage of modifier 56. The following determinations have been made based on the individual indicators. • This modifier cannot be used on procedures unless the Glob Days field is equal to 010 or 090 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid with modifier 56 and global surgery days other than 010 and 090 will be denied unless Medicaid has instructed differently through provider bulletins and/or manuals. • This modifier can only be used on procedures which have a Glob Days field equal to 010 or 090 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid that has been assigned global surgery days equal to 010 or 090 will process as normal. Complete definitions of the Glob Days indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009).
57		Modifier 57 indicates an E&M service resulted in the initial decision to perform surgery either the day before a major surgery (90-day global period) or the day of a major surgery (90-day global period). Modifier 57 can only be used on E&M codes. KMAP denies services billed with modifier 57 on codes other than E&M codes.
58	80, 81, 82, AS	It may be necessary to indicate the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. Complications from surgery which do not require a return trip to the operating room are considered part of the global surgery package from the original surgery and are not payable separately. Modifier 58 is not appropriate in this situation. ***Note*: For treatment of a problem that requires a return to the operating or procedure room (e.g., unanticipated clinical condition), see modifier 78.** Modifier 58 cannot be appended to ambulatory surgical center (ASC) facility fee claims. Modifier 58 cannot be appended to a procedure with "XXX" in the Glob Days field on the Medicare Physician Fee Schedule Relative Value File. Complete definitions of the Glob Days indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009).
59	76	Modifier 59 can be used for a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury. The following example illustrates the appropriate usage of this modifier: A patient with a leg wound comes in for a culture of the site of the wound. The lab tech obtains independent specimens per the order, one from the proximal wound site and one from the distal wound site. This is coded as follows: 87071 (for the proximal site) and 87071 59 (for the distal site). Modifier 59 is appropriately appended to the second code to identify it was a different site from the first specimen. Modifier 59 cannot be used on E&M service codes or on code 77427. KMAP denies E&M codes and code 77427 when billed with modifier 59. Documentation must be submitted with the claim which supports that a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. Modifier 59 should only be used if another more descriptive modifier is not available. Modifiers XE, XP, XS, or XU should be used if the clinical situation described by one of those modifiers is present.
62	26, 66, 80, 81, 82, AS, TC	When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon must report his or her distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedure(s) are performed during the same surgical session, separate code(s) can also be reported with modifier 62 added. ***Note:*** If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services can be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

Modifier	Invalid Combination	Special Coding Instructions
63		Procedures performed on neonates and infants up to a present body weight of four kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance can be reported by adding modifier 63 to the procedure code. Modifier 63 can only be appended to procedures/services listed in the 20000-69990 code series of the *CPT* codebook. Modifier 63 cannot be appended to any codes listed in the E&M, Anesthesia, Radiology, Pathology/Laboratory, or Medicine series of codes in the *CPT* codebook. The *CPT* codebook lists codes for which modifier 63 cannot be reported. KMAP denies codes other than 20000-69990 when billed with modifier 63.
66	26, 62, 80, 81, 82, AS, TC	Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances can be identified by each participating physician with the addition of modifier 66 to the basic procedure code used for reporting services.
73		Submit modifier 73 for ASC facility charges when the surgical procedure is discontinued before anesthesia is administered. This modifier cannot be submitted by the operating surgeon. Only ASCs can submit this modifier. Surgeons can refer to modifier 53. Modifier 73 is used by the facility to indicate a surgical or diagnostic procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well-being of the patient after the patient had been prepared for the procedure (including procedural premedication when provided) and taken to the room where the procedure was to be performed but prior to administration of anesthesia. This modifier code was created so the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) can be recognized for payment even though the procedure was discontinued.
74		Submit modifier 74 for ASC facility charges when the surgical procedure is discontinued after anesthesia is administered. This modifier cannot be submitted by the operating surgeon. Only ASCs can submit this modifier. Surgeons can refer to modifier 53. Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block, or general) or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. For a physician reporting a discontinued procedure, see modifier 53. This modifier was created so the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) can be recognized for payment even though the procedure was discontinued prior to completion.
76	59, 77	When a diagnostic procedure is performed during separate patient encounters (such as, different times of the day), the second code can be reported with modifier 76. Do not use modifier 76 when the definition of the code indicates a repeated procedure or redo (such as 57511). Modifier 76 is used when the procedure is repeated by the same physician subsequent to the original service. The repeat service must be identical to the initial service provided. This modifier is separate and distinct from modifiers 58, 78, and 79. Refer to details for these modifiers. If the same procedures are performed on the same day, they must be billed on the same claim. If the duplicative service is not billed on the same claim, a duplicate denial of the service will occur. Although valid, this modifier does not document payable services during the global period, therefore rendering this modifier invalid for use with a surgical code. Repeat procedures for treatment of complications can be billed with modifier 78. Repeat procedures for Clinical Diagnostic Laboratory codes can be billed with modifier 91 not 76. The Medicare Clinical Diagnostic Laboratory Fee Schedule from the CMS website is used to determine which procedures are considered to be Clinical Diagnostic Lab procedures. KMAP denies surgical and clinical diagnostic laboratory codes when billed with modifier 76.
77	76	Modifier 77 is used when a procedure is repeated by a different physician subsequent to the original service; the repeat service must be identical to the initial service provided. Use modifier 77 to report the same procedure performed more than once on the same date of service but at different encounters. Repeat procedures for clinical diagnostic laboratory codes can be billed with modifier 91 instead of modifier 77.

Modifier	Invalid Combination	Special Coding Instructions
77	76	KMAP denies clinical diagnostic laboratory codes when billed with modifier 77. The Medicare Clinical Diagnostic Laboratory Fee Schedule from the CMS website is used to determine which procedures are considered Clinical Diagnostic Lab procedures. Modifier 77 cannot be used with E&M services 92002 – 92014, and 99201 – 99499. KMAP will deny all E&M services submitted with modifier 77. If denied, physicians must remove the modifier and resubmit the claim. For rules regarding where multiple physicians in the same group with the same specialty are performing E&M services on the same day for the same patient, refer to the Wisconsin Physicians Service (WPS) website.
78	80, 81, 82, AS	KMAP uses the Medicare Physician Fee Schedule Relative Value file from the CMS website to determine which procedures are appropriately billed with modifiers 78 and 79. KMAP uses the Glob Days field on the file as a basis to determine proper usage of modifiers 78 and 79. The following determinations have been made based on the individual days assigned. These modifiers can only be used on surgical procedures with global days equal to 000, 010, 090, MMM, YYY, or ZZZ on the Medicare Physician Fee Schedule Relative Value file. Any surgical procedure billed to Medicaid with modifier 78 or 79 that does not have global days of 000, 010, 090, MMM, YYY, or ZZZ will be denied. Complete definitions of the Glob Days indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009).
79		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
80	54, 55, 58, 62, 66, 78, 79	Surgical assistant services can be identified by adding modifier 80 to the usual procedure code. Use modifier 80 when the assistant at surgery service is provided by a medical doctor (MD). Modifier 80 can only be used by professional providers. It should not be used by a hospital. This modifier can only be submitted with surgery codes. Physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) cannot submit this modifier. See modifier AS. **Modifier 80 is a processing modifier, and the rate is 25% of the base code.**
81	54, 55, 58, 62, 66, 78, 79	Although a primary operating physician may plan to perform a surgical procedure alone, during the operation circumstances can arise requiring the services of an assistant surgeon for a relatively short time. In this instance, the second surgeon provides minimal assistance, for which he or she reports the surgical procedure code with modifier 81. Modifier 81 can only be used by professional providers. It should not be used by a hospital. This modifier can only be submitted with surgery codes. PAs, NPs, and CNSs must not submit this modifier. See modifier AS. **Modifier 81 is a processing modifier, and the rate is 25% of the base code.**
82	54, 55, 58, 62, 66, 78, 79	The prerequisite for using modifier 82 is the unavailability of a qualified resident surgeon. In certain programs (such as teaching hospitals), the physician acting as the assistant surgeon is usually a qualified resident surgeon. However, there are times (such as during rotational change) when a qualified resident surgeon is not available, and another surgeon assists in the operation. In these instances, the services of the nonresident assistant surgeon are reported with modifier 82. Use modifier 82 when the assistant at surgery service is provided by an MD when there is not a qualified resident available. Documentation must include information relating to the unavailability of a qualified resident in this situation. Modifier 82 can only be used by professional providers. It should not be used by a hospital. This modifier can only be submitted with surgery codes. PAs, NPs, and CNSs must not submit this modifier. See modifier AS. **Modifier 82 is a processing modifier, and the rate is 25% of the base code.**
90		The American Medical Association (AMA) developed modifier 90 for use by a physician or clinic when laboratory tests for a patient are performed by an outside or reference laboratory. Although the physician is reporting the performance of a laboratory test, this modifier is used to indicate the actual testing component was provided by a laboratory. When the physician bills the patient for laboratory work performed by an outside or (reference) laboratory, modifier 90 is added to the laboratory procedure code. Physicians use this modifier when laboratory procedures are performed by a party other than the treating or reporting physician. Modifier 90, when appropriate, should only be used on laboratory procedure codes. KMAP will deny services billed on any codes other than laboratory procedure codes.

Modifier	Invalid Combination	Special Coding Instructions
90		Hospitals, physicians and independent laboratories must confirm the CLIA status of the performing laboratory prior to billing KMAP for those services. Referring providers are required to confirm the CLIA status for the performing lab prior to billing KMAP for those services. This is noted on the claim with the use of Modifier 90 - Reference (outside) Laboratory.
91	76, 77	During the course of patient treatment, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by the addition of modifier 91. Modifier 91 is used to identify a lab test performed more than once on the same day for the same patient when multiple results are necessary for proper treatment. For example, a patient with diabetic ketoacidosis has multiple blood tests performed to check potassium level after potassium replacement and low-dose insulin therapy. After the initial potassium value is measured, three subsequent blood tests are ordered and performed on the same date after the administration of potassium to correct the patient's hypokalemic state. This is coded as follows: 84132 (initial test), 84132-91, 84132-91, 84132-91. KMAP uses the Medicare Clinical Diagnostic Laboratory Fee Schedule (CDLFS) from the CMS website as the basis for determining proper usage of modifier 91. Modifier 91 can only be used on Clinical Diagnostic Laboratory procedure codes. KMAP will deny services billed with modifier 91 for codes other than those identified on the Medicare CDLFS.
92		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.
93		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only and used for audio-only telemedicine.
95		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.
96		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.
97		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.
99		This modifier is reportable on all procedure codes. This modifier must not be used when reporting less than five modifiers for a single detail line of service.
A1 **A2** **A3** **A4** **A5** **A6** **A7** **A8** **A9**		Modifiers A1 through A9 indicate a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and also indicate the number of wounds on which that dressing is being used. The modifier number must correspond to the number of wounds on which the dressing is being used, not the total number of wounds treated. Modifiers A1 through A9 are used for informational purposes and are not required. However, if you choose to bill with these modifiers, they should only be used on the following codes: A4550-A4649, A6010-A6512, and A9270. KMAP denies services billed on codes other than those listed. For further information, refer to the *Home Health Agency Fee-for-Service Provider Manual*.
AA		Anesthesia modifiers are required for procedure codes 00100-01989, 01991-01995, and 01997-01999. This anesthesia modifier must be reported with anesthesia services in the first modifier field to indicate who performed the anesthesia service. Anesthesia services billed without one of these modifiers will be denied. Anesthesia modifiers submitted on services other than anesthesia will cause the service to be denied.
AD		Anesthesia modifiers are required for procedure codes 00100-01989, 01991-01995, and 01997-01999. This anesthesia modifier must be reported with anesthesia services in the first modifier field to indicate who performed the anesthesia service. Anesthesia services billed without one of these modifiers will be denied. Anesthesia modifiers submitted on services other than anesthesia will cause the service to be denied. Services billed to KMAP with this modifier will be denied as noncovered.
AE		This modifier can be submitted with claims for Medical Nutrition Therapy (MNT) and Diabetes Self-Management Training (DSMT). HCPCS codes: G0108-G0109 and G0270-G0271 *CPT* codes: 97802-97804
AF **AG**		These modifiers can be submitted with all HCPCS and *CPT* codes.

Modifier	Invalid Combination	Special Coding Instructions
AH		Submit this modifier with diagnostic psychological tests and therapeutic psychotherapy performed by a clinical psychologist. This modifier can be submitted with the following procedure codes. *CPT* codes: 90802, 90803, 90806, 90808, 90826, 90828, 90830-90856, 90863-90885, 90899, and 96105-96120, 96130, 96131. HCPCS codes: G0071, G0077, G0079, G0081, G0083, G0085, G0087, and G0089.
AI		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
AJ		Submit this modifier with diagnostic psychological tests and therapeutic psychotherapy performed by a clinical social worker. This modifier can be submitted with the following procedure codes: *CPT* codes: 90802, 90806, 90808, 90826, 90828, 90841-90856, and 90875-90876, 90885 HCPCS codes: G0071, G0077, G0079, G0081, G0083, G0085, G0087, G0089, G90806, and G90808.
AK **AM**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
AP		This modifier can be submitted with *CPT* codes 92002, 92004, 92012, and 92014.
AQ **AR**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
AS	54, 55, 58, 62, 66, 78, 79	Use modifier AS for assistant at surgery services provided by a PA, NP, and CNS. Modifier AS can only be used by the professional providers identified. It should not be used by a hospital. **Modifier AS is a processing modifier and the rate is 25% of the base code.**
AT		This modifier can only be used on *CPT* codes 98940, 98941, and 98942. KMAP denies services billed with modifier AT on codes other than 98940, 98941, and 98942.
AV		KMAP uses the Medicare DME, Prosthetics/Orthotics & Supplies Fee Schedule from the CMS website to determine which procedures are appropriately billed with modifiers AV and AW. Procedure codes allowed to be billed with modifier AV or AW will appear on the file with modifier AV or AW (such as A4450 AV or A4450 AW). KMAP will deny any procedure billed to Medicaid that includes modifier AV or AW and is not found on this file.
AX		This modifier should be used on services furnished in conjunction with dialysis services. KMAP has determined the following list of service codes is appropriate for use with modifier AX. **Dialysis Supplies Billed with Modifier AX** A4215, A4216, A4217, A4244, A4245, A4246, A4247, A4248, A4450, A4452, A4651, A4652, A4657, A4660, A4663, A4670, A4927, A4928, A4930, A4931, A6216, A6250, A6260, A6402 **Dialysis Equipment Billed with Modifier AX** E0210, E1632, E1637, E1639 KMAP denies services billed with modifier AX except the codes listed.
AY		This modifier was developed for Medicare purposes. Medicare uses this modifier as an end stage renal disease (ESRD) consolidated billing requirement for services included in the ESRD facility bundled payment. At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
AZ		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
BA		Modifier BA must be used for items being supplied in conjunction with total parenteral nutrition (TPN). For parenteral supplies, add modifier BA to the base code (XXXXX-BA) and place in Field 24D when billing for items and supplies in conjunction with TPN. For further billing/coding instructions, refer to the *Home Health Agency Fee-for-Service Provider Manual* and *DME/Medical Supply Dealer Fee-for-Service Provider Manual*.
BL		This modifier was developed for Medicare purposes. Medicare uses this modifier for hospitals when an Outpatient Prospective Payment System (OPPS) provider purchases blood or blood products from a community blood bank or when an OPPS provider assesses a charge for blood or blood products collected in its own blood bank that reflects more than blood processing and storage.

Modifier	Invalid Combination	Special Coding Instructions
BO		Modifier BO must be used for oral supplemental nutrition in KBH-EPSDT-eligible members. For enteral supplies, add modifier BO to the base code (XXXXX-BO) and place in Field 24D when billing for oral supplemental nutrition. For further billing/coding instructions, refer to the *Home Health Agency Fee-for-Service Provider Manual* and *DME/Medical Supply Dealer Fee-for-Service Provider Manual*.
BP		For further information related to the usage of modifier BP, refer to *Durable Medical Equipment Bulletin 9102c* from November 2009.
BR **BU**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
CA		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
CB		This modifier was developed for Medicare payment purposes. **Medicare Usage** Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD member's dialysis benefit is not part of the composite rate and is separately reimbursable. **Guidelines/Instructions** Submit this modifier only when it has been determined that ALL of the following apply: • The patient is entitled to Medicare based on ESRD. • The test is related to the dialysis treatment for ESRD. • The test was ordered by a doctor providing care to patients in the dialysis facility. • The test is not included in the dialysis facility's composite rate payment.
CC		This modifier is not to be used by the provider community. It is an internal modifier identifying when the carrier changes the procedure code submitted.
CD **CE** **CF**		These modifiers were developed for Medicare purposes. Medicare uses these modifiers as pricing modifiers to identify the different payment situations for ESRD Automated Multi-Channel Chemistry (AMCC) services. The ESRD clinical diagnostic laboratory tests identified with modifiers CD, CE, or CF cannot be billed as organ or disease panels. However, KMAP has determined it would be appropriate for modifiers CD, CE, and CF to be used only on the following codes: 82040, 82247, 82248, 82310, 82330, 82374, 82435, 82465, 82550, 82565, 82947, 82977, 83615, 84075, 84100, 84132, 84155, 84295, 84450, 84460, 84478, 84520, 84550. If these modifiers are billed to Medicaid on codes other than the ones listed, the service will be denied.
CG		This modifier can be submitted with all HCPCS and *CPT* codes.
CH **CI** **CJ** **CK** **CL** **CM** **CN**		These modifiers are for informational purposes only. Refer to the *CPT* codebook.
CR		HCPCS modifier CR is used by Medicare to track and facilitate claims processing for disaster victims. This modifier can only be submitted with services that are related to a disaster or catastrophe, such as Hurricane Katrina in 2005.
CS		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
CT		This modifier should be submitted when a computed tomography (CT) service is completed using equipment that does not meet the National Electric Manufacturers Association XR-29-2013 standard. This modifier is used for pricing when submitted with procedure codes in the following ranges: 70450-70498, 71250-71275, 72191-72194, 73200-73206, 73700-73706, 74150-74178, 74261-74263, and 75571-75574. The technical component of these procedures will be reduced by 15%.
DA		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
E1 **E2** **E3** **E4**		These modifiers are anatomic-specific modifiers. These modifiers are for surgical and diagnostic services. These modifiers are not for E&M services. When eyelid procedures are coded, instead of modifier RT or LT, the procedure code must be appended with modifiers E1 through E4 to indicate upper and lower eyelid.

Modifier	Invalid Combination	Special Coding Instructions
E1 **E2** **E3** **E4**		For example: **Same Claim –** Detail Line Item 1: 67916 E1; Detail Line Item 2: 67916 E3
EA **EB** **EC** **EA** **EB** **EC**		CMS uses these modifiers to gather information to determine the prevalence and severity of anemia associated with cancer therapy, the clinical and hematologic responses to the institution of antianemia therapy, and the outcomes associated with various doses of antianemia therapy. If these modifiers are used, they are only valid when submitted with the following codes on non-ESRD claims for ESAs: J0881, J0882, J0885, J0886, and Q4081.
ED **EE**		CMS uses these modifiers for national claims monitoring for ESAs administered to ESRD patients receiving dialysis in a renal dialysis facility. Submit these modifiers when the following criteria are met: - The ESA is administered to an ESRD patient receiving dialysis in a renal dialysis facility. - The patient's hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dl) for three or more consecutive billing cycles immediately prior to and including the current billing cycle.
EJ		This modifier is purely informational and can be submitted with many HCPCS J-codes for injections.
EM		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
EP		Modifier EP is to be used for EPSDT services where modifier 32 was previously used. Modifier 32 is no longer valid for EPSDT services. CMS no longer recognizes *CPT* codes 99202, 99211, and 99212 as qualifying EPSDT screens. These codes are no longer valid for EPSDT screens and should not be billed with modifier EP.
ET		This modifier is for informational use only and can be submitted with codes 99281-99285, 99291, and 99292. Physicians and mid-level practitioners should use codes 99281-99285 and 99291-99292 for emergency room visits without modifier ET. For further billing and coding instructions, refer to the *Hospital Fee-for-Service Provider Manual* or *Professional Fee-for-Service Provider Manual*.
EX		This modifier is informational. It can be used to identify an expatriate member.
EY		CMS instituted modifier EY to allow DME suppliers to submit claims to Medicare for items without a prescription. Since there is no physician or provider information to report on claims for these items, modifier EY is used in conjunction with a surrogate unique physician identification number (UPIN) in the ordering/referring provider name fields of the claim. This protocol was adopted so that suppliers could obtain a Medicare denial which could be sent to a secondary insurer for COB purposes. Services and supplies billed to KMAP with modifier EY will be denied. KMAP will not reimburse for services or supplies not ordered by a licensed health care provider.
FA		This modifier is an anatomic-specific modifier and is appropriate for surgical and diagnostic services. This modifier is not appropriate for E&M services.
FB		This modifier is intended for use with procedures or devices submitted by ASCs. ASCs must append modifier FB to the HCPCS device procedure code when the device is furnished without cost or with full credit and only when billed with the associated implantation procedure code found in **List A** below. A single code should not be submitted with both modifiers FB and FC. For further billing instructions, refer to CMS CR7275. This modifier can be reported with the following HCPCS codes for devices: C1721, C1722, C1764, C1767, C1771, C1772, C1776, C1777, C1778, C1779, C1820, C1833, C1881, C1882, C1889, C1891, C1895, C1896, C1897, C1898, C1899, C2626, C2631, and L8614. **List A**: 33206, 33207, 33208, 33210, 33211, 33212, 33213, 33214, 33216, 33217, 33285, 33286, 36566, 53440, 53444, 53445, 53447, 54400, 54401, 54405, 54410, 62362, 63650, 63655, 63685, 64553, 64555, 64561, 64568, 64584, 64590, and 69930.
FC		This modifier is intended for use with procedures or devices submitted by ASCs. ASCs must append modifier FC to the HCPCS device procedure code for the surgery when a device is furnished with a partial credit for a replacement device. A single procedure code should not be submitted with both modifiers FB and FC. For further billing instructions, refer to CMS CR7275. This modifier can be reported with the following HCPCS codes for devices: C1721, C1722, C1764, C1767, C1771, C1772, C1776, C1777, C1778, C1779, C1785, C1786, C1813,

Modifier	Invalid Combination	Special Coding Instructions
FC		C1815, C1820, C1833, C1881, C1882, C1889, C1891, C1895, C1896, C1897, C1898, C1899, C1900, C2619, C2620, C2621, C2622, C2626, C2631, and L8614. **List A**: 33206, 33207, 33208, 33210, 33211, 33212, 33213, 33214, 33216, 33217, 33240, 33249, 33224, 33225, 33285, 33286, 36566, 53440, 53444, 53445, 53447, 54400, 54401, 54405, 54410, 54416, 61885, 61886, 62361, 62362, 63650, 63655, 63685, 64553, 64555, 64561, 64568, 64575, 64577, 64580, 64581, 64584, 64590, and 69930.
FP		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
FQ **FR** **FS** **FT**		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
FX	FY	Modifier FX was created to identify claims where an X-ray service was furnished using film. Payment for the technical component of procedures submitted with modifier FX are reduced by 20%.
FY	FX	Modifier FY was created to identify claims where an X-ray service was furnished using computed radiography technology/cassette-based imaging. Payment for the technical component of procedures submitted with modifier FY are reduced by 7%.
G1 **G2** **G3** **G4** **G5** **G6**		Modifiers G1 through G6 are used for reporting the urea reduction ratio (URR) for determining the adequacy of hemodialysis. KMAP will deny the service if billed with any of these modifiers for codes other than G0491, G0492, and 90999.
G7		This modifier can only be submitted with the following *CPT* codes: 00940, 1965, 01966, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, S0190, S0191, S0199, and S2260. KMAP will deny the service if this modifier is billed with any code other than those listed. For further information, refer to the *Professional Fee-for-Service Provider Manual*.
G8	QS	Modifier G8 should only be used with the following anesthesia codes: 00100, 00160, 00300, 00400, 00532, and 00920. This modifier can be reported in the second position under appropriate circumstances in addition to anesthesia modifiers AA, AD, QK, QX, QY, and QZ (billed in the first position).
G9		This anesthesia modifier can be submitted on procedure codes 00100-01989, 01991-01995, and 01997-01999. This modifier can be reported in the second position under appropriate circumstances in addition to anesthesia modifiers AA, AD, QK, QX, QY, and QZ (billed in the first position). Anesthesia modifiers submitted on services other than anesthesia will cause the service to be denied.
GA **GB**		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
GC		Modifier GC must be used by the physician for teaching physician services. A teaching physician service billed using this modifier is certifying that he or she has been present during the key portion of the service and was immediately available during the other parts of the service.
GD		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
GE		Submit this modifier with services performed by a resident in a teaching facility without the presence of a teaching physician. This modifier is informational and can only be submitted with procedure codes included in the primary care exception. HCPCS code: G0402 *CPT* codes: 99202, 99203, 99211, 99212, 99213, 93005, and 93041.
GF		For services rendered in a CAH by a NP, CNS, CRN, or PA, use this modifier.
GG		Modifier GG is used when a diagnostic and a screening mammogram are performed on the same day for the same patient. Modifier GG is added to the diagnostic mammography code only. Both the diagnostic and screening codes must be billed on the same claim form. Submit modifier GG with the diagnostic mammography code. CMS uses this modifier for tracking and data collection purposes. This modifier can be submitted with the following: *CPT* codes: 76706, 77051, 77055, 77056, 77065, and 77066. KMAP will deny the service if this modifier is billed with any code other than those listed.

Modifier	Invalid Combination	Special Coding Instructions
GH		When a screening mammogram indicates a potential problem, the interpreting radiologist can order additional films during the same visit on the same day without an additional order from the treating physician. The radiologist must report to the treating physician the condition of the patient. These additional films, with the report to the treating physician, convert a screening mammogram to a diagnostic mammogram. The procedure code is reported with modifier GH to indicate the radiologist converted the screening mammogram to a diagnostic mammogram. This modifier can be submitted with *CPT* codes: 76706, 77055, 77056, 77065, and 77066. KMAP will deny the service if this modifier is billed with any code other than those listed.
GJ		This modifier is used specific to Medicare. Medicare rules: Physicians who have opted out of Medicare (also called private contracting) are not permitted to submit services to Medicare; however, the exception to this rule is when services are provided on an emergent or urgent basis. Opt-out physicians and practitioners must submit these services to Medicare with modifier GJ. To opt out of Medicare, physicians and practitioners who are permitted to opt out must follow certain procedures and guidelines.
GK **GL**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
GN		Submit modifier GN to indicate the services were delivered under an outpatient speech language pathology plan of care. KMAP has determined it is appropriate to use modifier GN on the following codes: 20999, 53899, 90901, 92520, 92507, 92508, 92521-92524, 92526, 92597, 92605, 92606, 92607, 92608, 92609, 92610, 92611, 92612, 92614, 92616, 95851, 95852, 96105, 96110, 96111, 96125, 97010, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97014, 97032, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97169-97172, 97530, 97533, 97535, 97537, 97542, 97597, 97598, 97602, 97605, 97606, 97610, 97750, 97755, 97760, 97761, 97763, 97799, G0281, G0283, and G0329. KMAP will deny the service if this modifier is billed with any code other than those listed.
GO		Submit modifier GO to indicate services delivered under an outpatient occupational plan of care. KMAP has determined it is appropriate to use modifier GO on the following codes: 20999, 53899, 90901, 92520, 92507, 92508, 92521-92524, 92526, 92597, 92605, 92606, 92607, 92608, 92609, 92610, 92611, 92612, 92614, 92616, 95851, 95852, 96105, 96110, 96111, 96125, 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97169-97172, 97530, 97533, 97535, 97537, 97542, 97597, 97598, 97602, 97605, 97606, 97610, 97750, 97755, 97760, 97761, 97763, 97799, G0281, G0283, and G0329. KMAP will deny the service if this modifier is billed with any code other than those listed.
GP		Submit modifier GP with services delivered under an outpatient physical therapy plan of care. KMAP has determined it is appropriate to use modifier GP on the following codes: 20999, 53899, 90901, 92520, 92507, 92508, 92521-92524, 92526, 92597, 92605, 92606, 92607, 92608, 92609, 92610, 92611, 92612, 92614, 92616, 95851, 95852, 96105, 96110, 96111, 96125, 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97169-97172, 97530, 97533, 97535, 97537, 97542, 97597, 97598, 97602, 97605, 97606, 97610, 97750, 97755, 97760, 97761, 97763, 97799, G0281, G0283, and G0329. KMAP will deny the service if this modifier is billed with any code other than those listed.
GQ		KMAP has determined modifier GQ can only be submitted with the following codes: 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 96116, 97802, 97803, 99202, 99203, 99204, 99205, 99206, 99207, 99208, 99209, 99210, 99211, 99212, 99213, 99214, 99215, 99246, 99247, 99248, 99249, 99250, 99261, G0270, G0406, G0407, G0408, G0508, G0509, H0001, H0004, H0005, H0006, H0007, H0015, H0038, T1030, T1031, and Q3014. KMAP will deny the service if this modifier is billed with any code other than those listed.
GR		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
GS		This modifier can be submitted with codes: J0881, J0882, J0885, J0886, and Q4081. KMAP will deny the service if this modifier is billed with any code other than those listed.
GU **GV**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.

Modifier	Invalid Combination	Special Coding Instructions
GW		
GX		This modifier can be submitted with all HCPCS and *CPT* codes, as applicable.
GY		Refer to the *Home Health Agency Fee-for-Service Provider Manual*.
GZ		Medicare will automatically deny any service with modifier GZ appended as not medically necessary. The denial will reflect a claim adjustment reason code (CARC) of 50 and a group code of contractual obligation (CO) to show provider/supplier liability because an Advance Member notice was not issued to the member. Medicaid will also follow Medicare policy and begin automatically denying any services with a modifier GZ appended as not medically necessary with a CARC of 50 and a group code of CO.
H9		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
HA		It is appropriate to use modifier HA with the following codes if billing for services in a child/adolescent program: H0032, H0036, and T1019. KMAP will deny the service if this modifier is billed with any code other than those listed.
HB		It is appropriate to use modifier HB with code H0036, when applicable.
HC **HD**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
HE		Modifier HE can be billed with code T1019, when applicable.
HF **HG**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
HH		It is appropriate to bill modifier HH with code H0036, when applicable.
HI		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
HJ		It is appropriate to bill modifier HJ on code H0036, when applicable. KMAP will deny the service if this modifier is billed with any code other than H0036.
HK		Code 90847 with modifier HK is only covered for provider specialty (PS) 125 for provider types (PTs) 11, 31, and 09.
HO		Codes H00031 and H2011 can be billed with modifier HQ when provided by a Masters level clinician. KMAP will deny the service if this modifier is billed with any code other than those listed.
HQ		Codes H2017, H0038, and S9482 can be billed with modifier HQ when provided in a group setting. KMAP will deny the service if this modifier is billed with any code other than those listed.
HR **HS** **HT** **HU** **HV** **HW** **HX** **HY** **HZ**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
J1 **J2** **J3** **J4**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers. At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
JA **JB**		These modifiers are informational only and can be submitted with all injection codes.
JC **JD**		Modifiers JC and JD can be used with codes Q4100-Q4114.
JG		Modifier JG was created to identify claims where drugs or biologicals were acquired with the 340B Drug Pricing Program discount. Payment for drugs or biologicals submitted with modifier JG will be reduced by 28%. If you are required to report modifier JG to Medicare and the recipient has Kansas Medicaid, then this modifier must also be reported to Kansas Medicaid.
JW		Modifier JW should be billed on the detail line that denotes the discarded portion of the drug or biological. The amount administered to the patient should be billed on a separate detail

Modifier	Invalid Combination	Special Coding Instructions
JW		line without modifier JW. Both details are reimbursable. This applies to claims for dual- and Qualified Medicare Member (QMB)-eligible only.
K0 **K1** **K2** **K3** **K4**		Prosthetic claims for knees, feet and ankles should be submitted with modifiers K0-K4, indicating the expected patient functional level. These modifiers can be submitted with codes L5000-L5999. KMAP will deny the service if these modifiers are billed with any code other than those listed.
KA **KB**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
KC		KMAP uses the Medicare Durable Medical Equipment, Prosthetics/Orthotics & Supplies Fee Schedule to determine which procedures are appropriately billed with modifier KC. Procedure codes allowed to be billed with modifier KC will appear on the file with the modifier KC (such as E2312 KC). KMAP will deny any procedure billed to Medicaid that includes modifier KC and is not found on this file.
KD		Use modifier KD to indicate the administration of a drug through a DME home infusion pump.
KE **KF** **KG** **KH** **KI** **KJ** **KK**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
KL **KM** **KN**		KMAP uses the Medicare Durable Medical Equipment, Prosthetics/Orthotics & Supplies Fee Schedule to determine which procedures can be billed with modifiers KL, KM, and KN. Applicable procedure codes appear on the file with modifier KL, KM, or KN (such as A4233 KL, L8040 KM, L8047 KN). Any procedure not listed will be denied by KMAP.
KO		Use modifier KO when a single drug is dispensed in a unit dose container. Modifier KO should not be used with the concentrated form codes or HCPCS code J7621.
KP **KQ** **KP** **KQ**		Use modifiers KP and KQ when two or more drugs are combined and dispensed to a patient in the same unit dose container. Add modifier KP to one of the unit dose form codes and modifier KQ to all other unit dose codes. The use of modifiers KP and KQ should result in a combination yielding the lower cost to the member. Modifiers KP and KQ are not used with the concentrated form codes or HCPCS code J7621.
KR		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
KS	KX	Modifier KS must be used if the member is not insulin treated (noninsulin-dependent diabetic). Modifier KX must be used if the member is insulin treated (insulin-dependent diabetic). Modifiers KX and KS cannot be billed together on a single detail line. If a modifier is not included, the claim will deny. For further instructions, refer to the *Home Health Agency Fee-for-Service Provider Manual* and *DME/Medical Supply Fee-for-Service Provider Manual*.
KT **KU** **KV**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
KW		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
KX	KS	Modifier KX can be used for different purposes. It must be used to identify services that are gender-specific. Documentation must be on file to support the use of modifier KX. Modifier KX must also be used if the member is insulin treated (insulin-dependent diabetic). Modifier KS must be used if the member is not insulin treated (noninsulin-dependent diabetic). Modifiers KX and KS cannot be billed together on a single detail line. If a modifier is not included, the claim will deny. For further instructions, refer to the *Home Health Agency Fee-for-Service Provider Manual* and *DME/Medical Supply Dealer Fee-for-Service Provider Manual*.
KY		If a service is billed with modifier KY, it will be denied.
KZ		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.

Modifier	Invalid Combination	Special Coding Instructions
LC		Under certain circumstances, a physician may need to indicate a procedure or service was distinct or independent from other services performed on the same day. HCPCS modifier LC is used to identify situations when it is appropriate to submit these specific *CPT* codes for separate reimbursement and can be used with the following *CPT* codes: 92920-92944, 92978, 92979, and 93971.
LD		This modifier can be submitted with the following *CPT* codes: 92920-92944, 92973, 92978, 93571, and 93572.
LL		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
LM		This modifier is for informational purposes only. Refer to the *CPT* codebook.
LO		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
LR		Modifier LR can only be submitted by independent clinical laboratories with HCPCS codes P9603 and P9604. KMAP will deny the service if billed on any other codes.
LS		Submit on physician claims for eye surgery with intraocular lens (IOL) implants.
LT	50	For further information related to the usage of modifier LT, refer to the *Professional Fee-for-Service Provider Manual*, *Vision Fee-for-Service Provider Manual*, and *Audiology Fee-for-Service Provider Manual*.
M2		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
MS		Maintenance and servicing for DME is not covered.
NB		Modifier NB is valid for use with HCPCS codes E0550-E0585.
NR		Use modifier NR when DME which was new at the time of rental is subsequently purchased.
NU		KMAP uses the Medicare DME, Prosthetics/Orthotics & Supplies Fee Schedule to determine which procedures are appropriately billed with modifier NU. Procedure codes listed on the file with modifier NU can be billed with this modifier (such as A4233 NU). Any procedure code not listed on this file with modifier NU will be denied.
P1 **P2** **P3** **P4** **P5** **P6**		Modifiers P1 through P6 can be used with anesthesia procedure codes 00100-01999. These modifiers identify the appropriate physical status of the patient and distinguish the various levels of complexity of the anesthesia service provided. KMAP will deny the service if these modifiers are billed with any code other than those listed.
PA **PB** **PC**		Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. They include all procedures described by the codes in the Surgery section of the *CPT* codebook and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood. A surgical or other invasive procedure is considered the wrong procedure if it is inconsistent with the correctly documented informed consent for that patient. A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is inconsistent with the correctly documented informed consent for that patient including surgery on the right body part but the wrong location on the body. This includes left versus right (appendages and/or organs) or at the wrong level (spine). ***Note:*** Emergent situations occurring during the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation or due to the discovery of an unusual physical configuration (such as, adhesions, spine level/extra vertebrae).

Modifier	Invalid Combination	Special Coding Instructions
PA **PB** **PC**		A surgical or other invasive procedure is considered to have been performed on the wrong patient if the procedure is inconsistent with the correctly documented informed consent for that patient. Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate Type of Bills (TOBs) are required to append one of the following applicable National Coverage Determinations (NCD) modifiers to all lines related to the erroneous surgery(s): PA, PB, or PC.
PI		Modifier PI must be used for positron-emission tomography (PET) or PET/computed tomography (CT) scans done to determine the initial treatment strategy for tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing, one per cancer diagnosis.
PL		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
PN		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier is for informational use only.
PS		Modifier PS must be used for PET or PET/CT scans done to determine the subsequent treatment strategy of cancerous tumors when the member's treating physician determines it is needed to determine subsequent anti-tumor strategy.
PT		Submit this modifier with the appropriate *CPT* code for colonoscopy, flexible sigmoidoscopy, or barium enema when the service is initiated as a colorectal cancer screening service but becomes a diagnostic service. Modifier PT is valid for use with *CPT* codes 00811 - 00812 and 10000-69999. See the MLN Matters article, MM7012 and MM10181.
Q0 **Q1** **Q2**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
Q3		Submit modifier Q3 with live kidney donor preoperative, intraoperative, and postoperative services.
Q4		This modifier is informational only and can be submitted with the following codes. *CPT* codes: 80002 – 89399 HCPCS codes: G0058 – G0060
Q5 **Q6**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
Q7 **Q8** **Q9**		Modifiers Q7, Q8, and Q9 can be used with the following codes: G0127, 11055, 11056, 11057, 11719, 11720, and 11721. KMAP will deny the service if these modifiers are billed with any code other than those listed.
QC **QD**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
QE		Modifier QE can be used with codes E0424, E0439, E1390, and E1391. This modifier must not be used with codes for portable systems or oxygen contents.
QF **QG** **QH**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
QJ		Modifier QJ indicates the provider has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient that state or local law makes the prisoner or patient responsible to repay the cost of medical services. Collection of debts incurred for furnishing such items or services is pursued with the same vigor and in the same manner as any other debt.
QK		Anesthesia modifiers are required for procedure codes 00100-01989, 01991-01995, and 01997-01999. This anesthesia modifier must be reported with anesthesia services in the first modifier field to indicate who performed the anesthesia service. Anesthesia services billed without one of these modifiers will be denied. Anesthesia modifiers submitted on services other than anesthesia will cause the service to be denied. Services billed to KMAP with this modifier will be denied as noncovered.
QP		It is appropriate to use modifier QP when the laboratory test was ordered as a single test or when a single code is available for a grouping of tests. Modifier QP indicates the test was ordered individually or ordered as a recognized panel other than automated profile codes 80002-80019 and G0058-G0060. Modifier QP can be submitted with codes 80100-89356. KMAP will deny the service if this modifier is billed with any code other than those listed.

Modifier	Invalid Combination	Special Coding Instructions
QS		Anesthesia modifiers are required for procedure codes 00100-01989, 01991-01995, and 01997-01999. This anesthesia modifier must be reported with anesthesia services in the second modifier field to indicate who performed the anesthesia service. Anesthesia services billed without one of these modifiers will be denied. Anesthesia modifiers submitted on services other than anesthesia will cause the service to be denied.
QT		This modifier can be submitted with all HCPCS and *CPT* codes.
QW		The regulations of the Clinical Laboratory Improvement Amendments (CLIA) of 1988 require a facility to be appropriately certified for each test performed. Procedures that **do not** require modifier QW include *CPT* codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, 85651, and HCPCS code G0394. To ensure CMS pays only for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level. KMAP uses the List of Waived Tests file to determine which procedures are appropriately billed with modifier QW. KMAP will deny the service if this modifier is billed with any code other than those identified on the List of Waived Tests file.
QX		Anesthesia modifiers are required for procedure codes 00100-01989, 01991-01995, and 01997-01999. This anesthesia modifier must be reported with anesthesia services in the first modifier field to indicate who performed the anesthesia service. Anesthesia services billed without one of these modifiers will be denied. Anesthesia modifiers submitted on services other than anesthesia will cause the service to be denied.
QY		Anesthesia modifiers are required for procedure codes 00100-01989, 01991-01995, and 01997-01999. This anesthesia modifier must be reported with anesthesia services in the first modifier field to indicate who performed the anesthesia service. Anesthesia services billed without one of these modifiers will be denied. Anesthesia modifiers submitted on services other than anesthesia will cause the service to be denied. Services billed to KMAP with this modifier will be denied as noncovered.
QZ		Anesthesia modifiers are required for procedure codes 00100-01989, 01991-01995, and 01997-01999. This anesthesia modifier must be reported with anesthesia services in the first modifier field to indicate who performed the anesthesia service. Anesthesia services billed without one of these modifiers will be denied. Anesthesia modifiers submitted on services other than anesthesia will cause the service to be denied.
RA		Modifier RA is used for a replacement due to loss, irreparable damage, or theft of a DME, orthotic, or prosthetic item. Modifier RA must only be used on the first month rental claim for a replacement item. Modifier RA must be present on all claims for replacement hearing aids. This modifier can be submitted with the following codes, when applicable: V5030, V5040, V5050, V5060, V5090, V5241, V5242, V5243, V5244, V5245, V5246, V5247, V5254, V5255, V5256, and V5257.
RB		Modifier RB can be used on a DME POS claim to indicate replacement parts of a DME, orthotic, or prosthetic item furnished as part of the service of repairing the item.
RC		This modifier can be submitted with the following *CPT* codes: 92920-92944, and 92973.
RD		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
RE		Modifier RE can be submitted with all procedure codes, as appropriate.
RI		This modifier is for informational purposes only. Refer to the *CPT* codebook.
RP		Modifier RP can be used to indicate replacement of DME, orthotic, and prosthetic devices which have been in use for some time. Modifier RP will no longer be recognized for the use of repair and replacement. Modifiers RA and RB can be used instead.
RR		For further information, refer to the *DME/Medical Supply Dealer Fee-for-Service Provider Manual*.
RT	50	For further information related to the usage of modifier RT, refer to the *Professional Fee-for-Service Provider Manual*, *Vision Fee-for-Service Provider Manual*, and *Audiology Fee-for-Service Provider Manual*.
SA **SB** **SC** **SD**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
SE		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.

Modifier	Invalid Combination	Special Coding Instructions
SF		Modifier SF can be submitted with the following *CPT* codes, when applicable: 66820, 66821, 66830, 66840, 66850, 66915, 66920, 66930, 66940, 66945, 66983, 66984, and 66985.
SG		Modifier SG is no longer required by Medicare for ASC facility charges. Medicaid does not require modifier SG to be used with ASC facility charges. For ASC facility charges for procedures which are discontinued prior to the induction of anesthesia, see also *CPT* modifier 73. For ASC facility charges for procedures which are discontinued after administration of anesthesia, see also *CPT* modifier 74.
SH		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
SJ		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier.
SL		Modifier SL can be used for vaccine codes, when appropriate. Modifier SL can ONLY be used to designate a vaccine shortage if the CDC has declared a specified shortage. Modifier SL can no longer be used to cover a vaccine if there is an individual provider shortage, especially as it relates to the VFC program. Claims with modifier SL will be denied if the CDC has not declared a vaccine shortage of the specific vaccine. For further information, refer to the *KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Fee-for-Service Provider Manual* and *Home Health Agency Fee-for-Service Provider Manual*.
SM **SN** **SQ**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
SS **ST** **SU** **SV**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
SW		Submit modifier SW with the following codes when provided by a certified diabetes educator: Diabetes Self-Management Training (DSMT): HCPCS codes G0108-G0109 Medical Nutrition Therapy (MNT): *CPT* codes 97802-97804, HCPCS codes G0270-G0271.
SY		Use modifier SY only with the following codes for immunization, when appropriate: 90371, 90375, 90376, 90385, 90460, 90461, 90471, 90472, 90473, 90474, 90585, 90586, 90632, 9063390647, 90648, 90655, 90656, 90657, 90658, 90759, 90660, 90675, 90691, 90700, 90702, 90707, 90713, 90714, 90715, 90716, 90717, 90732, 90733, 90740, 90743, 90744, 90746, 90747, G0008, G0009, and G0010. KMAP will deny the service if this modifier is billed with any code other than those listed.
T1 **T2** **T3** **T4** **T5** **T6** **T7** **T8** **T9**		Modifiers T1 through T9 are appropriate for surgical and diagnostic services. These modifiers are not appropriate for E&M services. Modifiers T1 through T9 are appropriate for surgical and diagnostic services. These modifiers are not appropriate for E&M services.
TA		This modifier is appropriate for surgical and diagnostic services, not for E&M services.
TB		If required to report modifier TB to Medicare and the recipient has Kansas Medicaid, then this modifier must also be reported to Kansas Medicaid.
TC	26, 50, 62, 66	If billing for the global component (both professional & technical) of a procedure, modifiers 26 and TC must not be used. KMAP uses the Medicare Physician Fee Schedule Relative Value file to determine which procedures are appropriately billed with modifier TC. KMAP uses the PT/TC indicator field on the file as a basis to determine proper usage of modifier TC. The following determinations have been made based on the individual indicators. - This modifier must not be used on procedures which have a PC/TC indicator equal to 0, 2, 3, 4, 5, 6, 8, and 9 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid which has been assigned one of these indicators will be denied unless Medicaid has instructed differently through provider bulletins and/or manuals. This modifier must only be used on procedures which have a PT/TC indicator equal to 1 or 7 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to

Modifier	Invalid Combination	Special Coding Instructions
TC	26, 50, 62, 66	Medicaid that has been assigned either indicator will continue to process as normal. Complete definitions of the PC/TC indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009).
TD		KMAP will deny the service if this modifier is billed with any code other than codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, or 99395. For further information refer to the *General Benefits Fee-for-Service Provider Manual*, *RHC-FQHC Fee-for-Service Provider Manual*, *HCBS TA Fee-for-Service Provider Manual,* and *HCBS I/DD Fee-for-Service Provider Manual*.
TE **TF** **TG** **TH**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
TJ		Modifier TJ is appropriate for use with codes H2017 and S5110. KMAP will deny the service if this modifier is billed with any code other than H2017 and S5110.
TK		Modifier TK is used for an extra patient or passenger. Modifier TK can only be used for the member who is not the primary rider with procedure codes A0130, T2002, and T2003. It can be used for a maximum of two units per member, per day. Mileage (such as A0425) cannot be billed on a claim with TK. It can be used for C-NEMT services when a C-NEMT provider transports more than one member from the same pick-up point to the same destination or transports more than one member from the same pick-up point, dropping off one of the members at a destination before dropping the remaining member at the farthest destination. For further information, refer to Section 7000 of the *Nonemergency Medical Transportation Fee-for-Service Provider Manual*.
TL **TM** **TN**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
TR		For further information, refer to the *Head Start Facility Fee-for-Service Provider Manual*.
TS **TT** **TU** **TV** **TW**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
U1		Modifier U1 must be used in combination with codes G9148, G9149, G9150, S0221, S0280, S0281, and S0311 when billing for OneCare Kansas Services. Modifier U1 can be used with H2011 to indicate Mobile Crisis Intervention.
U2		Modifier U2 can be used with code T2040 by HCBS Financial Management Services Agency with Choice providers to indicate Financial Management self-directed services. Modifier U2 can also be billed by hospice providers with code T2042 to indicate Hospice Routine Home Care days 61 and after and with code G0299 to indicate Service Intensity Add-on services provided by an RN.
U3		Modifier U3 can be used with code H2027 to indicate Positive Behavior Supports treatment services and 90882 to indicate person-centered planning. KMAP will deny the service if this modifier is billed with any other codes. Refer to the *KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Fee-for-Service Provider Manual*.
U4		Modifier U4 can be used with code T2046 to indicate a hospice reserve bed day. Reserve bed days are paid at 67% and are limited to 10 days per confinement. KMAP will deny the service if this modifier is billed with any code other than T2046.
U5		Modifier U5 can be used on codes H0005, H0006, H0015, and T1017, when appropriate. KMAP will deny the service if this modifier is billed with any other codes. For further information, refer to General Bulletin 15185 (published in September 2015) and the *Targeted Case Management – Frail Elderly Fee-for-Service Provider Manual*.
U6		Modifier U6 can be used on codes S5125, S5126, T1017, or T1505, when appropriate. KMAP will deny the service if this modifier is billed with any other codes. For further information, refer to the *HCBS Physical Disability Fee-for-Service Provider Manual* or *HCBS Traumatic Brain Injury Fee-for-Service Provider Manual*.

Modifier	Invalid Combination	Special Coding Instructions
U7		Modifier U7 can be used on code T1017, when appropriate. KMAP will deny the service if this modifier is billed with any other code. For further information, refer to the *Money Follows the Person Fee-for-Service Provider Manual*.
U8		This modifier is to be used by mid-level practitioners in multispecialty clinic settings for billing codes 99202, 99203, 99204, and 99205 when program requirements are met.
U9		Modifier U9 can be used on codes S5125 or S5126, when appropriate. KMAP will deny the service if these modifiers are billed with any other codes. For further information, refer to the *HCBS Physical Disability Fee-for-Service Provider Manual* or *HCBS Traumatic Brain Injury Fee-for-Service Provider Manual*.
UA		Modifier UA can be used with code S5125, when appropriate, for Personal Care Services for HCBS Frail Elderly members in assisted living facilities, residential health care facilities, and home plus settings and for MFP Frail Elderly members in assisted living settings. KMAP will deny the service if this modifier is billed with any other code.
UB		Modifier UB can be used on codes T1017, S5125, or S5126, when appropriate. KMAP will deny the service if this modifier is billed with any other codes. For further information, refer to the *Targeted Case Management – Traumatic Brain Injury Fee-for-Service Provider Manual, HCBS Physical Disability Fee-for-Service Provider Manual,* or *HCBS Traumatic Brain Injury Fee-for-Service Provider Manual*.
UC		Modifier UC can be used on code T2048 when billing for reserve days.
UD		Modifier UD can be used on codes S5125 or S5135, when appropriate. KMAP will deny the service if this modifier is billed with any codes other than S5125 or S5135. For further information, refer to the *HCBS Frail Elderly Fee-for-Service Provider Manual*.
UE		KMAP uses the Medicare DME, Prosthetics/Orthotics & Supplies Fee Schedule to determine which procedures are appropriately billed with modifier UE. Applicable procedure codes appear on the file with modifier UE (such as A4611 UE). Any procedure not listed with modifier UE will be denied by KMAP.
UF **UG** **UH** **UJ**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers.
UK		Modifier UK can be used for services provided on behalf of the member to someone other than the member (collateral relationship). It can be used when a C-NEMT provider transports a member with an accompanying parent, guardian, or designee. This modifier can only be used with codes A0130, T2002, T2003, and T2005. It can be used for a maximum of two units per member, per day. Mileage (such as A0425) can only be billed for the member, not the accompanying person. Refer to Section 7000 of the *Nonemergency Medical Transportation Fee-for-Service Provider Manual*.
UN **UP** **UQ** **UR** **US** **UN** **UP** **UQ** **UR** **US**		Use modifiers UN, UP, UQ, UR, and US with code R0075, when appropriate. The units field must reflect 1 except in extremely unusual circumstances. The units field must never be used to report the number of patients served during a single trip. The units field must reflect the number of services the specific member received, not the number of services received by other members. KMAP will deny the service if these modifiers are billed with any code other than R0075. ***Note:*** If only one patient is seen at a particular location, report code R0070 without a modifier.
V1 **V2** **V3**		At this time, there are no special coding instructions applicable to Medicaid claims billing for these modifiers. These modifiers are for informational use only.
VP		This modifier is informational only and can be submitted with the following service categories: Medical Care, Surgery, Consultation, Diagnostic Radiology, Anesthesia, Assistant at Surgery, Other Medical Items or Services, Ambulatory Surgical Center, and Facility Usage for Surgical Services.
X1		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.
X2		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.

Modifier	Invalid Combination	Special Coding Instructions
X3		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.
X4		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.
X5		At this time, there are no special coding instructions applicable to Medicaid claims billing for this modifier. This modifier will be informational only.
XE		Modifier XE can be used if the service occurred during a separate encounter. Modifier 59 should no longer be used in these instances. Modifier XE cannot be used with E&M codes.
XP		Modifier XP can be used if the service was performed by a different practitioner. Modifier 59 should no longer be used in these instances. Modifier XP cannot be used with E&M codes.
XS		Modifier XS can be used if the service was performed on a separate organ or structure. Modifier 59 should no longer be used in these instances. Modifier XS cannot be used with E&M codes.
XU		Modifier XU can be used if the service is considered distinct and does not overlap the usual components of the main service. Modifier 59 should no longer be used in these instances. Modifier XU cannot be used with E&M codes.