MODIFIERS RECOGNIZED IN PROCESSING SERVICE CLAIMS
ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
Revised 01/01/2017

MOD	DESCRIPTION	HOW PAYMENT IS AFFECTED
25	Significant, separately identifiable E&M service same practitioner same day	May allow E&M payment separate from another service; requires supporting documentation
26	Professional component	Pays professional component only (*refer to practitioner fee schedule, Notes A, B, C)
50	Bilateral procedure	Bill procedure code one time with modifier and quantity "1" to indicate bilaterals performed; use only when note is A or B
51	Multiple procedures	Applies only to billing multiple NDCs (***refer to Chapter A-200 Practitioner Handbook Appendix A-8)
52	Reduced services	Goes to hand pricing, requires attachment of additional information
53	Discontinued procedure	Not payable; bill only for services completed
57	Decision for surgery	Goes to hand pricing to determine if payable outside surgical package
59	Distinct procedural service	Applies to Medicare crossovers only
62	Two surgeons	Each surgeon is paid at 50% state maximum
73	Discontinued outpatient procedure prior to anesthesia administration	Not payable; bill only for services completed
74	Discontinued outpatient procedure after anesthesia administration	Not payable; bill only for services completed
76	Repeat procedure by same practitioner	Applies to Medicaid claims when billing multiple NDCs (***refer to Chapter A-200 Practitioner Handbook Appendix A-8), or Medicare Crossover claims.
80	Assistant surgeon	Payment is based on minutes billed
81	Minimum assistant surgeon	Payment is based on minutes billed
82	Assistant surgeon when qualified resident surgeon not available	Payment is based on minutes billed
90	Reference (outside) laboratory	Not payable for APL or inpatient procedures or to independent labs
91	Repeat clinical diagnostic laboratory test	Applies to Medicare crossovers only
AH	Clinical psychologist	Billable only by FQHC and RHC
AJ	Clinical social worker	Billable only by FQHC and RHC
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Payment is based on minutes billed
AT	Acute Treatment	Sterilization permit not required when procedure performed for acute reason and not for sterilization purposes
E1	Upper left eyelid	Processes separately from same CPT with different eyelid modifier
E2	Lower left eyelid	Processes separately from same CPT with different eyelid modifier
E3	Upper right eyelid	Processes separately from same CPT with different eyelid modifier
E4	Lower right eyelid	Processes separately from same CPT with different eyelid modifier
EP	Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program	Service is processed as a Healthy Kids service

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F1	Left hand, second digit	Processes separately from same CPT with different digit modifier
F2	Left hand, third digit	Processes separately from same CPT with different digit modifier
F3	Left hand, fourth digit	Processes separately from same CPT with different digit modifier
F4	Left hand, fifth digit	Processes separately from same CPT with different digit modifier
F5	Right hand, thumb	Processes separately from same CPT with different digit modifier
F6	Right hand, second digit	Processes separately from same CPT with different digit modifier
F7	Right hand, third digit	Processes separately from same CPT with different digit modifier
F8	Right hand, fourth digit	Processes separately from same CPT with different digit modifier
F9	Right hand, fifth digit	Processes separately from same CPT with different digit modifier
FA	Left hand, thumb	Processes separately from same CPT with different digit modifier
FP	Service provided as part of family planning program	Service is processed as a family planning service
GB	Service no longer covered under global (all-inclusive encounter rate) payment	Applies only to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Encounter Rate Clinics (ERCs) billing private stock vaccines fee-for-service for children age birth through 18 with Title XXI (21) or State-Funded eligibility
GC	Service performed in part by a Resident under the direction of a teaching physician	Identifies service rendered by a Resident but billed under the NPI of the teaching physician
GE	Service performed by a Resident without the presence of a teaching physician under Medicare's primary care exception	Identifies service rendered by a Resident but billed under the NPI of the teaching physician
GN	Outpatient speech therapy	***refer to Therapy Handbook
GO	Outpatient occupational therapy	***refer to Therapy Handbook
GP	Outpatient physical therapy	***refer to Therapy Handbook
GT	Via interactive audio and video telecommunication systems	***refer to Chapter A-200 Practitioner Handbook, Section A-220.6.7 Telehealth
GW	Service not related to hospice patient's terminal condition	Processes as service outside hospice rate.
GZ	Item or service expected to be denied as not reasonable and necessary	Not payable
HD	Pregnant/parenting women's program	Service is processed as a postpartum depression screening
HE	Mental health program	Refer to A-220.6.4 Psychiatric Consultation
HO	Masters degree level	Billable only by FQHC and RHC
JW	Drug amount discarded/not administered	Identifies the drug amount remaining from a single use vial that is discarded/not administered
LC	Left circumflex coronary artery	Processes separately from same CPT with different coronary artery modifier
LD	Left anterior descending coronary artery	Processes separately from same CPT with different coronary artery modifier
LT	Left side	Processes separately from same CPT with RT modifier
NU	New equipment	Processes as Purchase
P1	Normal, healthy patient	Anesthesia converts to modifying units "0"
P2	Patient with mild systemic disease	Anesthesia converts to modifying units "1"
P3	Patient with severe systemic disease	Anesthesia converts to modifying units "2"
P4	Patient with severe systemic disease that is a constant threat to life	Anesthesia converts to modifying units "3"
P5	Moribund patient not expected to survive without the operation	Anesthesia converts to modifying units "4"
P6	Declared brain-dead patient whose organs are being removed for donor purposes	Anesthesia converts to modifying units "0"

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Q5	Service furnished by substitute physician under reciprocal billing arrangement	***refer to Chapter A-200 Practitioner Handbook, Section A-202.1 Charges
QL	Patient pronounced dead after ambulance called	Not payable
QM	Ambulance service provided under arrangement by a provider of services	Not payable
QW	CLIA waived test	Identifies a waived CLIA test
RC	Right coronary artery	Processes separately from same CPT with different coronary artery modifier
RR	Rental	Processes as rental
RT	Right side	Processes separately from same CPT with LT modifier
SA	Nurse practitioner rendering service in collaboration w/physician	Identifies service rendered by APN but billed under NPI of physician
SL	State supplied vaccine	Processes HPV vaccine to providers not enrolled with VFC (**refer to Note "M" of the Practitioners Fee Schedule Key). Refer to the most current Practitioner Fee Schedule
T1	Left foot, second digit	Processes separately from same CPT with different digit modifier
T2	Left foot, third digit	Processes separately from same CPT with different digit modifier
T3	Left foot, fourth digit	Processes separately from same CPT with different digit modifier
T4	Left foot, fifth digit	Processes separately from same CPT with different digit modifier
T5	Right foot, great toe	Processes separately from same CPT with different digit modifier
T6	Right foot, second digit	Processes separately from same CPT with different digit modifier
T7	Right foot, third digit	Processes separately from same CPT with different digit modifier
T8	Right foot, fourth digit	Processes separately from same CPT with different digit modifier
T9	Right foot, fifth digit	Processes separately from same CPT with different digit modifier
TA	Left foot, great toe	Processes separately from same CPT with different digit modifier
TC	Technical component	Pays technical component only (*refer to practitioner fee schedule, Notes A, B, C)
TH	OB treatment/services	Pays hospital fee-for-service for OB triage ONLY when there is no billable APL and appended to CPT code 99211
U1	Local modifier-Blood lead draw	Blood specimen drawn for lead analysis as part of Healthy Kids program (***refer to Chapter HK-200 Section 203.1)
U2	Local modifier-Home Health nursing assessment visit	Processes as assessment visit only (***refer to Home Health Handbook Section R-203.1)
U4	Local modifier-Pregnancy resulting from rape	Claim requires Abortion Payment Application, HFS form 2390
U5	Local modifier-Obstetrical/gynecological services	Processes as Ob/Gyn Direct Access service available without a referral
U7	Local modifier-Pregnancy resulting from incest	Claim requires Abortion Payment Application, HFS form 2390
U8	Local modifier-Pregnancy threatening the mother's life	Claim requires Abortion Payment Application, HFS form 2390
U9	Local modifier-Pregnancy endangering the mother's health	Claim requires Abortion Payment Application, HFS form 2390
UB	Local modifier-Psychiatric service rendered at a Community Mental Health Center	Effective for dates of service 07-01-2016 through 06-30-2017 only. Identifies a psychiatric service rendered in partnership with a Community Mental Health Center.
UD	Local modifier-340B Drug Provider	Identifies a 340B purchased drug

* Practitioner Fee Schedule
**Provider Informational Notices
***Provider Handbooks