South Dakota Medicaid
Authorized Modifiers

Effective 07/01/2022
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A modifier provides the means for a provider to indicate that a service or procedure was altered by a specific circumstance but not changed in its definition or code. Pursuant to ARSD 67:16:02:03.03, modifier codes must be included on a provider's claim for services if applicable. Claims with modifiers not contained in this list may only be billed if the modifier is considered informational and does not reflect a reduction in services. Modifiers affecting payment or included in this document must be listed first. All modifiers must be billed in accordance with guidance in the CPT codebook or HCPCS Level II book unless otherwise stated in this document.

Medical Services

Modifier	Description	Payment Effect
22	Increased Procedural Services	125% Established Fee
		No Established Fee - 40% Usual and Customary Charge (UCC)
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	None
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Service	None
27	Multiple Outpatient Hospital E/M Encounters on the Same Date	None
26	Professional Component	30% Established Fee for laboratory procedures
		40% Established Fee for non-laboratory procedures
		No Established Fee - 40% UCC

Modifier	Description	Payment Effect
32	Mandated Services *Service must meet medical necessity criteria.*	None
33	Preventative Services	None
47	Anesthesia by Surgeon	None
50	Bilateral Procedure	150% Established Fee
		No Established Fee - 40% UCC
51	Multiple Procedures	50% Established Fee
		No Established Fee - 30% UCC
52	Reduced Services	75% Established Fee
		No Established Fee 40% UCC
53	Discontinued Procedure	50% Established Fee
		No Established Fee 40% UCC
54	Surgical Care Only	75% Established Fee
		No Established Fee 40% UCC
55	Postoperative Management Only	25% Established Fee
		No Established Fee 40% UCC
56	Preoperative Management Only	25% Established Fee
		No Established Fee 40% UCC
57	Decision for Surgery	None
58	Staged or Related Procedure by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	None

Modifier	Description	Payment Effect
59	Distinct Procedural Service	100% Established Fee
		No Established Fee 30% UCC
62	Two Surgeons	50% Established Fee for each surgeon
		No Established Fee - 40% UCC
63	Procedures Performed on Infants Less than 4 kg	None
73	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	50% Established Fee
		No Established Fee - 40% UCC
74	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	50% Established Fee
		No Established Fee - 40% UCC
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	100% Established Fee
		No Established Fee - 40% UCC
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	100% Established Fee
		No Established Fee - 40% UCC
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following the Initial Procedure for a Related Procedure During the Postoperative Period	100% Established Fee
		No Established Fee - 40% UCC

Modifier	Description	Payment Effect
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	100% Established Fee
		No Established Fee - 40% UCC
80	Assistant Surgeon	20% Established Fee
		No Established Fee - 40% UCC
81	Minimum Assistant Surgeon	20% Established Fee
		No Established Fee - 40% UCC
82	Assistant Surgeon when qualified resident surgeon not available	20% Established Fee
		No Established Fee - 40% UCC
90	Reference (outside) Laboratory	None
91	Repeat Clinical Diagnostic Laboratory Test	None
92	Alternative Laboratory Platform Testing	None
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System	None
96	Habilitative services	None
97	Rehabilitative Services	None
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	20% Established Fee
		No Established Fee - 40% UCC
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant	90% Established Fee
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant	90% Established fee
FS	Medicare E/M services split or shared between a physician and non-physician practitioner in a same group facility setting.	None
GC	Service has been performed in part by a resident under the direction of a teaching physician	None
GT	Via interactive audio and video telecommunication systems. *The GT modifier must be included for all services provided via telemedicine.*	None

Modifier	Description	Payment Effect
GY	Item or service statutorily excluded or does not meet the definition of any Medicare benefit.	None
HM	Less than bachelor's degree level counselors *Services provided by a speech-language pathologist assistant must be billed by the supervising therapist using the HM modifier.*	90% Established Fee
JG	Drug or biological acquired with 340B drug pricing program discount.	Claim is Denied
JW	Drug amount discarded/not administered to any patient	Claim Pays at $0. Cannot be billed to the recipient.
JZ	Zero drug amount discarded / not administered to any patient	None
PA	Surgery, wrong body part	100% Reduction (No reimbursement)
PB	Surgery, wrong patient	100% Reduction (No reimbursement)
PC	Wrong surgery on patient	100% Reduction (No reimbursement)
PN	Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital	40% Established Fee
PO	Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments	40% Established Fee
Q6	Substitute physician or physical therapist	Claim is Denied
QW	Clinical Laboratory Improvement Amendment (CLIA) waived test. *Must be used by pharmacies when billing a Strep test or flu test. The claim must be submitted on a CMS 1500 or via 837P.*	None
SL	State supplied vaccine	Vaccine pays at $0. Administration code is reimbursed.
TB	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes.	Claim is Denied
TC	Technical component	70% Established Fee for laboratory procedures
		60% Established Fee for non-laboratory procedures

Modifier	Description	Payment Effect
		No Established Fee - 40% UCC
UN	Group Supported Employment *Append to Family Support waiver services if applicable.*	None
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter	None
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner	None
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	None
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	None

Anatomic Modifiers

Modifier	Description	Payment Effect
E1	Upper left, eyelid	None
E2	Lower left, eyelid	None
E3	Upper right, eyelid	None
E4	Lower right, eyelid	None
FA	Left hand, thumb	None
F1	Left hand, second digit	None
F2	Left hand, third digit	None
F3	Left hand, fourth digit	None
F4	Left hand, fifth digit	None
F5	Right hand, thumb	None
F6	Right hand, second digit	None
F7	Right hand, third digit	None
F8	Right hand, fourth digit	None
F9	Right hand, fifth digit	None
LC	Left circumflex coronary artery	None
LD	Left anterior descending coronary artery	None
LM	Left main coronary artery	None
LT	Left Side - Used to identify items for the left side of the body	None
RC	Right coronary artery	None
RI	Ramus Intermedius	None

Modifier	Description	Payment Effect
RT	Right Side- Used to identify items for the right side of the body	None
TA	Left foot, great toe	None
T1	Left foot, second digit	None
T2	Left foot, third digit	None
T3	Left foot, fourth digit	None
T4	Left foot, fifth digit	None
T5	Right foot, great toe	None
T6	Right foot, second digit	None
T7	Right foot, third digit	None
T8	Right foot, fourth digit	None
T9	Right foot, fifth digit	None

Anesthesia

Modifier	Description	Payment Effect
23	Unusual Anesthesia	100% Established Fee
		No Established Fee - 40% UCC
AA	Anesthesia services performed personally by anesthesiologist	None
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	None
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	None
QX	CRNA service: with medical direction by a physician	None
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	None
QZ	CRNA service: without medical direction by a physician	None
P1	A normal healthy patient	None
P2	A patient with mild systemic disease	None
P3	A patient with severe systemic disease	None

Modifier	Description	Payment Effect
P4	A patient with severe systemic disease that is a constant threat to life	None
P5	A moribund patient who is not expected to survive without the operation	None
P6	A declared brain-dead patient whose organs are being removed for donor purposes	Not covered

Behavioral Health

Modifier	Description	Payment Effect
AM	Physician, team member service *Psychiatric Service*	See Behavioral Health Fee Schedules
EY	No physician or other licensed health care provider order for this item or service *Social detox; City/County Meth Program Only*	See Behavioral Health Fee Schedules
GT	Via interactive audio and video telecommunication systems. *The GT modifier must be included for all services provided via telemedicine.*	None
HA	Child/adolescent program *Substance Use Disorder Providers should use the HA modifier to indicate child or adolescent program.* *CMHCs should use the HA modifier to indicate Psych/CNP CYF services and for MRT/ART services and assessments.*	See Behavioral Health Fee Schedules
HB	Adult program, non-geriatric *CARE modifier for Psych/CNP services.*	See Behavioral Health Fee Schedules
HD	Pregnant/parenting women's program	See Behavioral Health Fee Schedules
HE	Mental health program *Substance Use Disorder Providers should use the HE modifier to indicate an individual service.* *CMHCs should use the HE modifier to indicate a Managed Care Exemption when providing a mental health service.*	See Behavioral Health Fee Schedules

Modifier	Description	Payment Effect
HF	Substance abuse program *2.1/3.1 services; used for individuals receiving residential and outpatient services* *FQHCs and IHS/Tribal 638s programs enrolled as a substance use disorder agency must use the HF modifier for substance use disorder services in order to be paid at the encounter rate.*	See Behavioral Health Fee Schedules
HG	Opioid addiction treatment program *Intensive Meth Treatment Program; SD Women's Prison.*	See Behavioral Health Fee Schedules
HK	Specialized mental health programs for high-risk populations *IMPACT modifier for Psych/CNP services. Also used in combination with "HA" to identify ART services.*	See Behavioral Health Fee Schedules
HQ	Group setting	See Behavioral Health Fee Schedules
HV	Funded state addictions agency *Gambling Services*	See Behavioral Health Fee Schedules
HW	Funded by state mental health agency *Transitional CARE.*	See Behavioral Health Fee Schedules
SA	Nurse practitioner rendering service in collaboration with a physician *Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist.*	See Behavioral Health Fee Schedules
SE	State and/or federally-funded programs/services *LCBHS Impact.*	See Behavioral Health Fee Schedules
TN	Rural/outside providers' customary service area	See Behavioral Health Fee Schedules

Transportation

Modifier	Description	Payment Effect
59	Distinct procedural services	100% of the Established Fee
DH	Diagnostic/therapeutic site other than physician's office/hospital to a hospital	None
DS	Diagnostic/therapeutic site other than physician's office/hospital to a scene of accident/acute event	None
EH	Residential, domiciliary, or custodial facility to a hospital	None
GH	Hospital-based dialysis facility to a hospital	None

Modifier	Description	Payment Effect
GM	Multiple patients on one ambulance trip. *Providers must submit the appropriate origin and destination modifiers in the first modifier position and HCPCS modifier GM in the second modifier position.*	None
HD	Hospital to a diagnostic/therapeutic site other than physician's office/hospital	None
HE	Hospital to a residential, domiciliary, or custodial facility	None
HG	Hospital to a hospital-based dialysis facility	None
HH	Hospital to another hospital	None
HI	Hospital to a site of ambulance transport modes transfer	None
HJ	Hospital to a non-hospital-based dialysis facility	None
HN	Hospital to a skilled nursing facility	None
HP	Hospital to a physician's office	None
HR	Hospital to residence	None
HS	Hospital to a scene of accident or acute event	None
IE	Site of ambulance transport modes transfer to a residential, domiciliary, or custodial facility	None
IH	Site of ambulance transport modes transfer to a hospital	None
II	Site of ambulance transport modes transfer to another site of ambulance transport modes transfer	None
IN	Site of ambulance transport modes transfer to a skilled nursing facility	None
JH	Non-hospital-based dialysis facility to a hospital	None
NG	Skilled nursing facility to a hospital-based dialysis facility	None
NH	Skilled nursing facility to a hospital	None
NN	Skilled nursing facility to another skilled nursing facility	None
NP	Skilled nursing facility to a physician's office	None
NR	Skilled nursing facility to a residence	None
PH	Physician's office to a hospital	None
PI	Physician's office to a site of ambulance transport modes transfer	None
PR	Physician's office to a residence	None
QL	Patient pronounced dead after ambulance called *Do not bill for the service if the recipient dies before being transported and no medically necessary services were provided at the scene. It is recommended the provider include a trip report with the claim.*	None
QM	Hospital arranged secure medical transportation	150% Established Fee
QN	Ambulance furnished by provider	None
R	Residence	None
RD	Residence to a Diagnostic/therapeutic site other than physician's office/hospital	None
RE	Residence to a residential, domiciliary, or custodial facility	None

Modifier	Description	Payment Effect
RH	Residence to a hospital	None
RI	Residence to a site of ambulance transport modes transfer	None
RN	Residence to a skilled nursing facility	None
RP	Residence to a Physician's office	None
SH	Scene of Accident/Acute Event to Hospital	None
SS	Scene of Accident/Acute Event to another Scene of Accident/Acute Event	None
TK	Extra patient or passenger, non-ambulance	50% Established Fee
TN	Rural/outside providers' customary service area	150% Established Fee

Durable Medical Equipment, Prosthetics, Orthotics, and Nutrition

Code	Description	Payment Effect
AV	Items furnished in conjunction with a prosthetic devise, prosthetic or orthotic	None
BO	Orally administered nutrition, not by feeding tube	None
JW	Drug amount discarded/not administered to any patient	Claim Pays at $0. Cannot be billed to the recipient.
LT	Left Side Used to identify items for the left side of the body	None
NU	New Equipment	None
RB	Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair	None
RR	Rental Use the RR modifier when the DME is rented	None
RT	Right Side Used to identify items for the right side of the body	None
UE	Used Durable Medical Equipment (DME)	None