PAYMENT POLICY ID NUMBER 23-081

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Anatomical Modifier Requirement Policy

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO FLORIDA BLUE MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OF THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

Modifiers are two-character codes defined by the American Medical Association (AMA) Current Procedural Terminology (CPT®) manual and The Centers for Medicare & Medicaid Services (CMS). Modifiers are appended to CPT®/ Healthcare Common Procedure Coding System (HCPCS) codes to provide additional information about the service rendered. CMS has identified anatomical modifiers for fingers, toes, eyelids, coronary arteries, as well as modifiers for right or left side of the body, to facilitate correct coding of claims.

A critical element in claims filing is the submission of current and accurate codes to reflect the services provided. Correct coding is essential for correct reimbursement. Anatomical modifiers assist in identifying the highest level of specificity for coding of services.

This policy addresses the use of anatomical modifiers when submitting claims and applies to Florida Blue Commercial and Medicare Advantage services reported on a CMS-1500 claim or its electronic equivalent.

REIMBURSEMENT INFORMATION:

Florida Blue requires the following anatomic specific modifiers, when applicable, to indicate the area or part of the body on which the service is performed.

- E1-E4 (eyelids)
- FA-F9 (fingers)
- TA-T9 (toes)
- RC, LC, LD, RI, LM (coronary arteries), and
- RT / LT (right / left)

Anatomical modifiers should only be used if clinically supported. Modifiers should not be appended to a CPT®/HCPCS code(s) solely to bypass a National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edit. The use of anatomical modifiers is important to assist in prompt, accurate adjudication of claims. Inappropriate usage, or failure to report anatomical modifiers, may lead to unnecessary denials.

A claim should be submitted with the correct anatomic modifier-to-procedure code combination. Claims will be returned for reprocessing if a modifier is appended to a procedure code that does not match the appropriate anatomical site. Additionally, claims will be returned for reprocessing if an anatomical modifier necessary to differentiate right or left is omitted.

Anatomic modifiers appended to a procedure code should align with ICD-10 codes that specify laterality. Furthermore, claims should not be submitted with an anatomical modifier and an unspecific lateral diagnosis code, where laterality has been built into the ICD-10 description.

Modifiers 59, XU, XS, XP, XE should not be used in place of an anatomical modifier.

Anatomical modifiers should be utilized when the procedure or service is performed unilaterally. Modifier LT (left) or RT (right) should be used to indicate that a procedure that can be performed on the contralateral anatomic side is performed on only one side [bones, joints, paired organs (e.g., kidneys, lungs), or extremities (e.g., legs, arms)].

Services with anatomic modifiers are subject to the multiple procedure reductions (when applicable).

BILLING/CODING INFORMATION:

Providers should append the following anatomical modifiers for left and right side of the body, eyelids, hands, feet, and coronary arteries.

Side of Body Modifiers

Modifier	Descriptor
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)

Eye lid modifiers

Modifier	Descriptor
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid

Finger/digit of hand modifiers

Modifier	Descriptor
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit

Toe/digit of foot modifiers

Modifier	Descriptor
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

Coronary artery modifiers

Modifier	Descriptor
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LM	Left main coronary artery
RC	Right coronary artery
RI	Ramus intermedius coronary artery

RELATED MEDICAL COVERAGE GUIDELINES OR PAYMENT POLICIES:

Bilateral Procedures- Professional & Institutional Billing 10-005
National Correct Coding Initiative (NCCI) Edits 10-006

REFERENCES:

1. Centers for Medicare and Medicaid Services, NCCI Policy Manual for Medicare Services; Chapter 1. General Correct Coding Policies https://www.cms.gov/ncci-medicare/medicare-ncci-policy-manual
2. American Medical Association, Current Procedural Terminology (CPT®), Professional Edition
3. Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS); HCPCS Release and Code sets. https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update

GUIDELINE UPDATE INFORMATION:

10/19/2023	New policy established