

Anatomical Modifier Requirement Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

Table of Contents

[Application](#)

[Policy](#)

[Overview](#)

[Reimbursement Guidelines](#)

[Questions and Answers](#)

[Resources](#)

[History](#)

Application

This reimbursement policy applies to all Medicare Advantage products and for services reported using the 1500 Health Insurance Claim Form (a/k/a CMS 1500) or its electronic equivalent or its successor form. This policy applies to all network physicians and other qualified health care professionals.

Policy

Overview

This policy addresses the appropriate use of modifiers with certain CPT and HCPCS procedure codes. According to the Centers for Medicare and Medicaid Services (CMS), a modifier is a two-character code that is added, when appropriate, to the end of a procedure or service to clarify the services being billed. Modifiers add more information, such as the anatomical site, to the code. In addition, they help to eliminate the appearance of duplicate billing and unbundling. Modifiers are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data.

Reimbursement Guidelines

Surgical Codes – Anatomical Modifiers

Anatomical modifiers are used to designate the specific area of the body that a procedure was performed. Use of laterality and/or anatomical modifiers help to provide the highest specificity for the procedure being performed. UnitedHealthcare Medicare Advantage requires surgical procedure codes in the range of 10000-69999 assigned a bilateral indicator of “1” on the National Physician Fee Schedule to be billed with an anatomical modifier.

Laterality and/or Anatomical Modifiers

50	RT	LT	E1-E4	F1-F9
FA	T1-T9	TA	LC	LD
LM	RC	RI		

Questions and Answers

1.

Q: Will UnitedHealthcare consider reimbursement for a service rendered on the upper right eyelid appended with modifier RT instead of E3?

A: Providers should code to the highest specificity. The E3 modifier would be the most specific; however, claims billing with the RT modifier would be accepted.

Resources

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners Section: 30

Medicare Claims Processing Manual - Chapter 23 - Fee Schedule Administration and Coding Requirements Section 20.9.3.2

Centers for Medicare and Medicaid Services: PFS Relative Value Files

Local Coverage Article A56869 Billing and Coding: Use of Laterality Modifiers

The Medicare Learning Network (MLN): MLN1783722 Proper Use of Modifiers 59, XE, XP, XS, & XU



History	
1/23/2025	Policy Version Change Updated Overview and Resources sections
11/1/2024	Policy implemented by UnitedHealthcare Medicare Advantage
7/22/2024	Policy approved by the Reimbursement Policy Oversight Committee