

## Anatomical Modifier Requirement Policy, Professional

### **IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY**

*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 Community Plan reimbursement policies uses 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 and, when specified, to those billed on UB04 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 reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.*

**Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.**

*Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.*

*UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.*

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### Application

**This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.**

This reimbursement policy applies to services reported using either the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or the electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract 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

##### **Percutaneous Coronary Artery Interventions (PCI)**

Percutaneous coronary intervention (PCI), commonly known as coronary angioplasty or simply angioplasty, is a non-surgical procedure used to treat the stenotic (narrowed) coronary arteries of the heart found in coronary heart disease. According to the CMS National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, percutaneous coronary artery intervention (PCI) includes stent placement, atherectomy, and balloon angioplasty. There are CPT and HCPCS codes describing various combinations of these PCI procedures.

There are five major coronary arteries (left main, left anterior descending, left circumflex, right, and ramus intermedius), each having a corresponding descriptive anatomical modifier. UnitedHealthcare requires PCI codes be reported with one of the five anatomical PCI modifiers in order to be considered for reimbursement.

**PCI Codes**

92920	92924	92928	92933	92937	92941	92943
92973	92974	92975	C9600	C9601	C9602	C9603
C9604	C9605	C9606	C9607	C9608		

**PCI Modifiers**

LC	LD	LM	RC	RI
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**State Exceptions**

<b>States Exempt from Policy</b>	Arizona, Indiana, Kansas, Minnesota, Mississippi, Nebraska, Texas
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**Questions and Answers**

1	<b>Q:</b> Why aren't all anatomical modifiers addressed in this policy?
	<b>A:</b> The intent of the Anatomical Modifier Requirement Policy is to require modifier usage where appropriate with applicable services and is not meant to address all possible anatomical modifier situations.

**Resources**

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

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System

**History**

<b>10/27/2023</b>	Policy Version Change State Exceptions Section: Kentucky removed
<b>10/6/2023</b>	Policy Version Change State Exceptions Section Added
<b>9/10/2023</b>	Policy Version Change PCI Codes Section Updated
<b>8/1/2023</b>	Policy implemented by UnitedHealthcare Community Plan
<b>4/6/2023</b>	Policy approved by the Reimbursement Policy Oversight Committee