UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2024R9066A

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.

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

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Application

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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 Community Plan 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

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

11/1/2024	Policy implemented by UnitedHealthcare Medicare Advantage

7/22/2024	Policy approved by the Reimbursement Policy Oversight Committee