

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 may 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 the 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	C9600	C9601	C9602	C9603	C9604
C9605	C9606	C9607	C9608			

PCI Modifiers

LC	LD	LM	RC	RI
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Surgical and Radiological 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 specific Surgical codes (10000-69999 Series) and Radiological codes (70000 Series) to be billed with the appropriate anatomical modifier for the procedure performed within an anatomical site.

Laterality and/or Anatomical Modifiers

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

State Exceptions

Arizona	Arizona is exempt from this policy as they utilize their own state files
Idaho	Idaho is exempt from the Surgical and Radiological Codes portion of this policy
Indiana	Indiana is exempt from the Surgical Codes portion of this policy
Kentucky	Kentucky is exempt from the Surgical and Radiological Codes portion of this policy
Mississippi	Mississippi is currently exempt from this policy
Nebraska	Nebraska is exempt currently exempt from this policy
New Jersey	New Jersey is exempt from the Radiological Codes portion of this policy
Ohio	Ohio is exempt from the Surgical and Radiological Codes portion of this policy
Texas	Texas is exempt from the PCI and the Radiological Codes portion of this policy

Questions and Answers

1	Q: Why aren't all anatomical modifiers addressed in this policy?
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	A: 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.
2	<p>Q: Will UnitedHealthcare consider reimbursement for services rendered on a specific digit appended with the RT modifier instead of specific digit modifiers?</p> <p>A: Providers should code to the highest specificity. The Appropriate F1-F9, FA, T1-T9, TA modifier would be accepted. Claim lines billed may deny when billed without the highest specificity.</p>

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

5/10/2026	Policy Version Change State Exceptions Section: Kansas and Tennessee removed
3/1/2026	Policy Version Change State Exceptions Section: Colorado and North Carolina removed
2/6/2026	Policy Version Change State Exceptions Section: District of Columbia and Maryland removed State Exceptions Section: Idaho, Kansas, Kentucky, North Carolina, Ohio and Texas updated History Section: Entries prior to 2/6/2024 archived
2/1/2026	Policy Version Change Policy language update Policy Q&A Added State Exceptions Section: Colorado, Idaho, Kansas, New Jersey, Tennessee and Texas added
1/1/2026	Policy Version Change PCI Codes Section Updated History Section: Entries prior to 1/1/2024 archived
9/14/2025	Policy Version Change State Exceptions Section: District of Columbia, Indiana, Kentucky, Maryland, North Carolina and Ohio added State Exceptions Section: Mississippi and Nebraska updated
5/11/2025	Policy Version Change State Exceptions Section: Texas and Kansas removed
10/1/2024	Policy Version Change State Exceptions Section: Kansas, Mississippi, Nebraska and Texas updated
4/6/2023	Policy approved by the Reimbursement Policy Oversight Committee