JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.032
		Effective Date	09/15/2023
		Review Date	N/A
	Subject **Anatomic Modifiers**	*Revision Date*	09/15/2023
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Anatomic, Bilateral, Modifier

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I. ABOUT OUR REIMBURSEMENT POLICIES:

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

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II. PURPOSE:

In accordance with CMS and CPT guidelines, anatomic modifiers assist in identifying the highest level of specificity when coding for certain services and procedures. By utilizing specific modifier(s) this may also prevent denials for duplicative services and in some cases, reduce the additional need for medical record reviews and appeals. As such, JHHP will reject claims when an applicable procedure code is reported without the required modifier or is inconsistent with the modifier used. This coding requirement is consistent with CMS correct coding guidance and industry standards, to help ensure that claim adjudication and payment are processed quickly and accurately.

III. POLICY STATEMENT:

JHHP follows CMS, State, and American Medical Association (AMA) CPT/HCPCS guidelines and has identified codes that are not payable, not covered, or bundled (not separately reimbursed) which are applicable to this policy. Due to changes in CMS and State guidance, and provider contracts, additional codes may apply.

IV. BILLING GUIDELINES & PAYMENT METHODOLOGY:

A. APPROPRIATE USE OF ANATOMIC MODIFIERS

1. Anatomical modifiers will be required (when applicable), regardless of diagnosis code description, to ensure alignment with procedures and/or services rendered.
2. Appropriate anatomic modifiers application is applicable to DMEPOS, surgical services, imaging, diagnostic and therapeutic services, coronary procedures, etc.
3. Consistent with CMS, modifiers 59, XU, XS, XP, XE shall not be used in place of an anatomical modifier or to override NCCI Procedure to Procedure (PTP) edits.
4. Services with anatomic modifiers may be subject to multiple procedure reductions.
5. Do not report anatomical modifiers in addition to modifier 50**.**

B. BILATERAL PROCEDURES

1. Please refer to JHHP's Bilateral Procedures and Split Care Procedures policies for coding guidance and additional information.

C. CORONARY ANATOMIC MODIFIERS

1. JHHP aligns with both the NCCI and CPT book, which lists the same five major coronary arteries and recognizes the same branches for reporting purposes.
2. JHHP requires claims for Percutaneous Coronary Intervention (PCI) procedures include the appropriate modifiers to identify which vessel is undergoing a specific procedure.
3. PCI procedure codes are built on progressive hierarchies with more intensive services inclusive of lesser intensive services. Only one PCI code may be reported for each of up to two branches of a major coronary artery with recognized branches.
4. PCI of a third branch of a major coronary artery with recognized branches shall not be reported.
5. CPT codes 92921, 92925, 92929, 92934, 92938, and 92944 are considered status "B" (bundled) codes and will not be separately reimbursed.
    - Refer to Medicare Claims Processing Manual Ch. 23- Medicare Physician Fee Schedule Database (MPFSDB) Status Indicators for additional information.

D. DIAGNOSTIC and THERAPEUTIC SERVICES

1. Anatomic modifiers may be necessary when claims for diagnostic and therapeutic services are submitted.

2. For radiology services and other diagnostic procedures, HCPCS code, line item dates of service, units, and applicable HCPCS modifiers are required.
   - Please refer AMA CPT Manual, the HCPCS Level II Manual for additional guidanc**e.**

E. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, and SUPPLIES (DMEPOS)

1. Anatomic modifiers may be necessary when DMEPOS claims are submitted for the certain HCPCS codes.
2. When applicable, providers are expected to accurately report an item for the right or left side of the body or for a certain anatomical site (e.g., fingers, toes, foot, arm).
3. The right (RT) and left (LT) modifiers must be used when billing (including, but not limited to):
   - Prosthesis codes, additions, and replacement parts;
   - Refractive lenses codes;
   - Orthosis base codes, additions, and replacement parts;
   - Therapeutic shoes, inserts, or modifications
4. When the same code for bilateral items (left and right) is billed on the same date of service:
   - Bill each item on two separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line.
   - Do not use the RT/LT modifier on the same claim line and billed with 2 UOS.
   - Claims billed without modifiers RT and/or LT, or with RTLT on the same claim line and 2 UOS, will be rejected as incorrect coding.

F. MAXIMUM FREQUENCY USE

1. Anatomical modifiers E1-E4 (Eyes), FA-F9 (Fingers), and TA-T9 (Toes) have a maximum allowable of one unit, per anatomical site, on a single date of service.
2. Claims submitted with E1-E4, FA-F9, TA-T9 will be denied when any provider bills more than one unit of service.
   - Refer to the JHHP reimbursement policy on NCCI and MUE Edits for coding guidance and additional information.

EXAMPLE:

Two blepharoplasty procedures are performed during the same operative session, on both upper eye lids. The provider would code as follows:

- *15822-E1, billed with 1 unit, on one claim line;* ***and***
- *15822-E3, billed with 1 unit, on a separate claim line.*

In this scenario the provider should report the procedure as two separate line items and append the appropriate modifier. Failure to code to the highest level of specificity may cause *the second procedure to be denied, as it would be considered a duplicate.*

V. EXCEPTIONS:

N/A

VI. EXCLUSIONS:

1. Refer to JHHP's Non-Reimbursable Codes policy for non-covered services.
2. Refer to JHHP's Unlisted Codes policy.

VII. CODES, TERMS and DEFINITIONS:

Definition of Terms

Term	Definition
Bilateral Procedure	A procedure which can be performed on both sides of the body during the same session.
Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)	Are primarily and customarily used to serve a medical purpose rather than primarily for transportation, comfort or convenience. In alignment with CMS, JHHP considers DMEPOS to be items that meet the following criteria: • Can withstand repeated use. • Medically necessary and appropriate for the treatment of an illness or injury. • Generally is not useful to a person in the absence of an illness or injury. • Are appropriate for use in the home. • Are prescribed by a licensed physician/practitioner.
Percutaneous Coronary Intervention (PCI) Procedure	A non-surgical, invasive procedure with a goal to relieve the narrowing or occlusion of the coronary artery and improve blood supply to the ischemic tissue. This is usually achieved by different methods, the most common being ballooning the narrow segment or deploying a stent to keep the artery open.
Physician or Other Qualified Health Care Professional	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privilege (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN).

Anatomic Modifiers and Definitions: Append to a service or procedure that is performed on the hands, feet, eyelids, coronary artery or left and right side of the body.

Side of Body Modifiers			
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).

Eyelid Modifiers			
E1	Upper left, eyelid	E3	Upper right, eyelid
E2	Lower left, eyelid	E4	Lower right, eyelid

Hand Modifiers

FA	Left hand, thumb	F5	Right hand, thumb
F1	Left hand, second digit	F6	Right hand, second digit
F2	Left hand, third digit	F7	Right hand, third digit
F3	Left hand, fourth digit	F8	Right hand, fourth digit
F4	Left hand, fifth digit	F9	Right hand, fifth digit
Feet Modifiers			
TA	Left foot, great toe	T5	Right foot, great toe
T1	Left foot, second digit	T6	Right foot, second digit
T2	Left foot, third digit	T7	Right foot, third digit
T3	Left foot, fourth digit	T8	Right foot, fourth digit
T4	Left foot, fifth digit	T9	Right foot, fifth digit
Coronary Artery Modifiers and Branches			
LC	Left circumflex coronary artery	Marginals	
LD	Left anterior descending coronary artery	Diagonals	
LM	Left main coronary artery	No branches recognized for reporting purposes	
RC	Right coronary artery	Posterior descending, posterolaterals	
RI	Ramus Intermedius	No branches recognized for reporting purpose	

Modifiers

Modifier	**Definiton**
50	Bilateral Procedure
59	Distinct Procedural Service
XE	Separate Encounter, a service that is distinct because it occurred during a separate encounter.
XP	Separate Practitioner, a service that is distinct because it was performed by a different practitioner.
XS	Separate Structure, a service that is distinct because it was performed on a separate organ/structure.
XU	Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service.

MPFSDB Status Indicators

Status Indicator	Definition
A	Active code. These codes are separately paid under the physician fee schedule if covered.
B	Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident.
I	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services.
N	Non-covered service. These codes are carried on the HCPCS tape as non-covered services.
P	Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident.
X	Statutory exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule.

VIII. REFERENCES:

This policy has been developed through consideration of the following:

- Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services
- Medicare Claims Processing Manual – Chapter 20 – Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- NCCI for Medicare | CMS
- Novitas Medicare- Modifiers
- Proper Use of Modifiers 59, XE, XP, XS, and XU | CMS
- Regulations & Guidance | CMS
- TRICARE Reimbursement Manual

IX. APPROVALS:

Date	Review/Revision	Reason for Modification	Approved By
7/08/23	New	N/A	Reimbursement Policy Committee (RPC)

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