AETNA BETTER HEALTH® of Illinois Policy

Policy Name:	Anatomical Modifiers	Page:	1 of 5
Department:	Medical Payment Policy	Policy Number:	XXXX.XX
Subsection:		Effective Date:	04/06/2023
Applies to:	■ Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to provide a guide for the appropriate use of anatomical modifiers to adhere to correct coding to align with Centers for Medicare and Medicaid Services (CMS) standards. This policy applies to facility and professional claims.

STATEMENT OF OBJECTIVE:

According to our policy, which is based on CMS Policy, AMA Coding with Modifiers, AMA CPT Manual and the HCPCS Level II Manual, anatomic-specific modifiers designate the area or part of the body on which the procedure is performed. These modifiers are required whenever appropriate to provide additional clarity in the documentation, helping to avoid billing errors and ensuring that healthcare providers are reimbursed accurately. The use of anatomical modifiers is critical to meet payer requirements, facilitate proper claims processing, and maintain compliance with healthcare regulations.

DEFINITIONS:

Aetna Better Health of Illinois	A subsidiary of CVS Health Corporation, Medicaid subsidiary that provides plan management and other administrative services for the Louisiana Medicaid program.
The American Medical Association (AMA)	A professional group that publishes research to advance public health and advocates for the interests of registered physician-members.
Current Procedural Terminology (CPT)	A medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set (copyright protected by the AMA) describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

Healthcare Common Procedure Coding System (HCPCS)	Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items.
Illinois Department of Health Care and Family Services (HFS)	The Department of Healthcare and Family Services administers health insurance programs for children, pregnant women, and adults who are residents of Illinois.
Medicare (CMS)	Medicare is a health insurance program for: people age sixty-five (65) or older, people under age sixty-five (65) with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
Anatomical modifiers	Codes used to describe the specific body part, side, or location where a medical procedure or service has been performed. They help differentiate similar procedures that occur on different sides of the body (e.g., left vs. right), different levels of the body (e.g., upper vs. lower), or specific anatomical sites.
Side of Body Modifiers	
Modifier - RT	Right side
Modifier - LT	Left side
Modifier - 50	Bilateral
Eye Lid Modifiers	
Modifier – E1	Upper left eyelid
Modifier – E2	Lower left eyelid
Modifier – E3	Upper right eyelid
Modifier – E4	Lower right eyelid
Finger/Digit of Hand Modifiers	
Modifier - FA	Left hand thumb
Modifier – F1	Left hand, second digit

Modifier – F2	Left hand, third digit
Modifier – F3	Left hand, fourth digit
Modifier – F4	Left hand, fifth digit
Modifier – F5	Right hand, thumb
Modifier – F6	Right hand, second digit
Modifier – F7	Right hand, third digit
Modifier – F8	Right hand, fourth digit
Modifier – F9	Right hand, fifth digit
Toe/Digit of Foot Modifiers	
Modifier - TA	Left foot, great toe
Modifier – T1	Left foot, second digit
Modifier – T2	Left foot, third digit
Modifier – T3	Left foot, fourth digit
Modifier – T4	Left foot, fifth digit
Modifier – T5	Right foot, great toe
Modifier – T6	Right foot, second digit
Modifier - T7	Right foot, third digit
Modifier – T8	Right foot, fourth digit
Modifier – T9	Right foot, fifth digit

REIMBURSEMENT GUIDELINES:

Modifiers are two-character codes defined by the American Medical Association (AMA) Current Procedural Terminology (CPT) manual and The Centers for Medicare & Medicaid Services (CMS). Modifiers are appended to CPT/ Healthcare Common Procedure Coding System (HCPCS) codes to provide additional information about the service rendered. CMS has identified anatomical modifiers for fingers, toes, eyelids, right or left side of the body to facilitate correct coding of claims. Correct coding is essential for correct reimbursement.

Anatomical modifiers assist in identifying the highest level of specificity for coding of services. Providers must report services by appending applicable anatomical modifier(s) to procedures involving fingers, toes, eyes, and paired organs or structures as recognized by the Illinois Department of Health Care and Family Services (HFS).

LEGAL/CONTRACT REFERENCE:

- Federal and state laws, rules, and regulations concerning the practice of pharmacy, third party administration, Medicaid laws, rules, and regulations
- Applicable federal and state laws, regulations, and directives regarding the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])

FOCUS/DISPOSITION:

Responsibilities

The chief medical officer (CMO) and chief operating officer (COO) are responsible for review and implementation based upon state and federal regulation. Aetna Medicaid Administrators LLC applies editing rules as implemented by NCCI and AMA standards. Editing may also be developed based upon recommendations for specialty societies.

OPERATING PROTOCOL:

Systems

- Business application systems

Measurement

- Edit Accuracy
- Edit Application
- Overturn of Adjustment Rates

Reporting

- Aetna Medicaid - Cotiviti Healthcare Monthly Performance Summary to plan leadership
- Claim Check Monthly Summary to health plans

INTER-/INTRADEPENDENCIES:

Internal

- Medical Payment Policy
- Payment Integrity Center of Excellence, Service Operations (PIAB)
- Chief Medical Officer

- Chief Operating Officer
- Claims
- Finance
- Medical Management
- Special Investigations Unit

External

- Clinical Editing Vendors
- Practitioners
- Providers
- Regulatory Departments
- Vendors
- Aetna Better Health

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Review/Revision History	
Revised	08/25/2025