Aetna Better Health® of Illinois

Reimbursement Policy Statement Illinois Medicaid

Effective Date	Next Annual Review	Policy Number
04/06/2023	08/01/2027	ABHIL-RP-0016

Policy Name	Department
Anatomical Modifiers	Claims Operations Medical Payment

Policy Type			
Medical	Administrative	Pharmacy	Reimbursement

Aetna Better Health of Illinois (ABH IL) implements comprehensive and robust policies and procedures to ensure alignment with Illinois Department of Health Care and Family Services (HFS) and to warrant that regulatory standards are met.

ABH IL reimbursement policies are intended to provide a general reference for claims filing, coding, documentation guidelines and administrative functions. Providers are ultimately responsible for submission of accurate reporting of services provided.

Reimbursement of reported services is subject to member benefit, eligibility on date of service, medical necessity, related plan policies and procedures, correct coding and clinical editing logic, provider contracts and all applicable plan documentation and guidelines set forth by Illinois Department of Health Care and Family Services (HFS). Coding methodology, regulatory requirements, industry standard claims logic, guidance from specialty organizations and other factors are considered in the development of plan policies. ABH IL retains the right to change, amend or withdraw this policy as needed, at any time.

CONTENTS OF POLICY:

Aetna Better Health® of Illinois

A. Policy

This policy is provided as a guide to medical coding and editing guidelines for the appropriate use of anatomical modifiers. This guidance aligns with AMA CPT Coding Guidelines, CMS Healthcare Common Procedure Coding System (HCPCS) coding guidelines and Illinois Healthcare and Family Services (HFS) guidelines for reporting of services and supplies

B. Overview

This policy outlines the coding and editing guidelines for reporting procedures conducted on specific paired anatomical structures, distinct body parts or organs. Anatomical modifiers should be reported when additional information is needed to accurately describe how a service or procedure was performed and when indicated as required based on the service(s) provided in box 24D of the CMS-1500 paper form. This policy applies to all professional claim types.

Distinct Body Part Procedures

Distinct body part modifiers are used to designate the exact body part on which a procedure was performed. For procedures performed on eyelids, fingers or toes, the distinct body part modifier as listed in this policy should be appended to the procedure code with one unit reported. When the same procedure is conducted on similar anatomical sites (for example- on two finger digits) then the procedure should be reported twice with a quantity of one for each line with the distinct body part modifier appropriate, appended to each line.

Bilateral Procedures

Many surgical procedures can be performed bilaterally however correct reporting of the procedure will rely on the CPT code description of the procedure being reported. Procedures that are defined as bilateral in their code description do not require modifier RT, LT or 50 to correctly report the procedure when they are conducted bilaterally. When an appropriate bilateral procedure code is not available to report, the unilateral procedure code should be reported with the appropriate bilateral modifier appended.

C. Definitions

Term	Definition
Aetna Better Health of Illinois (ABHIL)	A subsidiary of CVS Health Corporation, Medicaid subsidiary that provides plan management and other administrative services for the Illinois Medicaid program.
American Medical Association (AMA)	A professional group that publishes research to advance public health and advocates for the interests of registered physician-members.

Anatomical Modifiers	A two-character code reported along with an applicable CPT code used to provide greater detail for procedures performed such. These codes 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.
Centers for Medicare & Medicaid Services (CMS)	The federal agency that administers the Medicare program as well as works with the individual states to administer state Medicaid and Children's Health Insurance Programs.
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 code set. Examples include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Level II HCPCS codes were established to allow these products, supplies and services to be reported for reimbursement.
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.
Medicaid	The state administered program that provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities, according to federal requirements. The program is funded jointly by states and the federal government.
Medicare	Medicare is a health insurance program for: people aged 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).

D. Reimbursement Guidelines

ABH IL will only reimburse for procedures/ services when appropriately reported with the specific anatomical modifier applicable when

- The procedure code reported applies to a specific paired organ or structure
- The procedure code reported applies to a distinct body part (fingers, toes or eyelids)
- The procedure code reported for a unilateral procedure which was conducted bilaterally is correctly reported with the appropriate modifier appended

Claims that are submitted will be denied when

- The anatomical modifier code reported does not match the organ, body part or structure reported by the CPT code
- The procedure reported is defined as requiring an anatomical modifier, but the correct or no anatomical modifier is not reported
- The procedure code reported for a unilateral procedure which was conducted bilaterally is reported without the appropriate bilateral modifier or an inappropriate modifier is appended.

The medical record documentation is expected to support the specific CPT code(s), ICD-10-CM, HCPCS code(s) and modifier(s) reported.

E. Codes/Condition of Coverage

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

F. Frequently Asked Questions

N/A

G. Review/Revision Date

Action	Date	Comments
Review	06/22/2026	Section B- additional reporting guidance added on bilateral and unilateral modifier reporting- no other content changes.
Review	10/07/2025	Policy template updated- no other content changes
Effective Date	04/06/2023	

H. Resources

1. American Medical Association. *HCPCS Level II Professional 2026, AMA;* 2025.
2. American Medical Association. *ICD-10-CM 2026 the Complete Official Codebook, AMA;* 2025.