KAISER PERMANENTE®

PAYMENT POLICY

SURGICAL CODES – ANATOMICAL MODIFIERS (PROFESSIONAL CLAIMS)

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington

☒ Kaiser Permanente Health Plan of Washington Options, Inc.

☒ Commercial

☒ Medicare

☐ Medicaid

Policy

Original Effective Date: 01/01/2021

When benefits allow, Kaiser Permanente will reimburse professional claims for surgical procedure codes in the range of 10000 – 69999 with a bilateral indicator of "1" on the Medicare Physician Fee Schedule when billed in the same session and/or performed at the same anatomical site, only when the line is billed with an anatomical modifier (50, LT, RT, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, LC, LD, RC, LM, RI).

Exclusions

CPT	Description
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)
29999	Unlisted procedure arthroscopy

30930	Fracture nasal inferior turbinate(s), therapeutic
36010	Introduction of catheter, superior or inferior vena cava
36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)
36012	Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)
36014	Selective catheter placement, left or right pulmonary artery
36015	Selective catheter placement, segmental or subsegmental pulmonary artery
36100	Introduction of needle or intracatheter, carotid or vertebral artery
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
37237	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty

	within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)
37501	Unlisted vascular endoscopy procedure
38220	Diagnostic bone marrow; aspiration(s)
38221	Diagnostic bone marrow; biopsy(ies)
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)
38500	Biopsy or excision of lymph node(s); open, superficial
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)
38589	Unlisted laparoscopy procedure lymphatic system
43289	Unlisted laparoscopy procedure esophagus
43659	Unlisted laparoscopic procedure stomach
44238	Unlisted laparoscopy procedure intestine xcp rectum
44979	Unlisted laparoscopy procedure appendix
47579	Unlisted laparoscopy procedure biliary tract
49329	Unlisted laparoscopy procedure abdomen peritoneum & omentum
49560	Repair initial incisional or ventral hernia; reducible
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated
49565	Repair recurrent incisional or ventral hernia; reducible
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated
49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)
49572	Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated
49590	Repair spigelian hernia
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible

49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated
55559	Unlisted laparoscopy procedure spermatic cord
58578	Unlisted laparoscopy procedure uterus
58579	Unlisted laparoscopy procedure uterus
59898	Unlisted laparoscopy procedure maternity care & delivery
60659	Unlisted laparoscopy procedure endocrine system

NOTE: Bilateral procedures billed on two separate lines with modifier 50 on one of the lines, are excluded from this policy.

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

https://www.onehealthport.com/sites/default/files/content-uploads/bpr/BPR_Claim_Coding_and_Edits.pdf:

“Mutually Exclusive Edit Table” This table contains 'edit pairs' of CPT/HCPCS codes that are mutually exclusive of one another based either on the CPT/HCPCS code descriptors or the medical impossibility/improbability that the two procedures could be performed at the same anatomical site or the same patient encounter. Note: many edits in the Mutually Exclusive edit table allow the use of NCCI-associated modifiers when, for example, the two procedures of a code pair edit may be performed at different anatomic sites or separate patient encounters on the same date of service.”

Medicare Claims Processing Manual, Chapter 23, Section 20.9.3.2:

“Providers or suppliers shall use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.”

Medicare MLN Connects Provider eNews:

“On October 1, 2015, ICD-10-CM will replace the ICD-9-CM code set currently used by providers for reporting diagnosis codes. Implementation of ICD-10-CM will not change the reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, providers will continue to follow CPT and CMS guidance in reporting CPT/HCPCS modifiers for laterality.”

Medicare NCCI Corresponding Language Manual:

“It is very important that NCCI PTP-associated modifiers only be used when appropriate. In general, these circumstances relate to separate patient encounters, separate anatomic sites, or separate specimens. (See subsequent discussion of modifiers in this section.) Most edits involving paired organs or structures (e.g., eyes, ears, extremities, lungs, kidneys) have NCCI PTP modifier indicators of “1” because the two codes of the code pair edit may be reported if performed on the contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated modifiers when performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations.” “If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, appropriate use of CPT modifiers (e.g., 59, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Each line of the claim with that HCPCS/CPT code will be separately adjudicated against the MUE value for that HCPCS/CPT code. Claims processing contractors have rules limiting use of these modifiers with some HCPCS/CPT codes.”

https://wa-provider.kaiserpermanente.org/static/pdf/provider/billing-claims/code-editing.pdf

Policy Definitions

Anatomical modifiers – modifiers that designate the area or part of the body on which the procedure is performed on different sites. This includes bilateral designation (right or left side of the body) and anatomically specific designations such as fingers, toes, and coronary arteries.

Prerequisite(s)

Not applicable

References

Medicare Claims Processing Manual, Chapter 23

National Correct Coding Initiative's (NCCI) General Correspondence Language and Section-Specific examples.

Frequently Asked Questions

Q1: What is the purpose of using a modifier?

A1: The use of a modifier on a claim provides additional information in the form of anatomical specificity for the code being billed and, if approved, may influence the payment for the code.

Q2: Why is the correct use of a modifier important?

A2: Several of the most common billing errors involve the incorrect use of modifiers. Correct modifier use is an important part of payment integrity by potentially preventing fraud and abuse or noncompliance issues, especially in coding and billing processes. Also, anatomical modifiers prevent inappropriate application of other edits such as duplication, maximum units from inappropriately being applied.

Revision History

08/29/2022 – Updated formatting

12/02/2020 – New policy effective 01/01/2021