Anatomical Modifiers

Reimbursement Policy ID: RPC.0089.5420

Recent review date: 01/2026

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Healthy DC reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Healthy DC may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines Healthy DC reimbursement guidelines for procedures that require an anatomical modifier denoting the side or part of the body where the procedure is performed.

Exceptions

N/A

Reimbursement Guidelines

CMS and CPT correct coding guidelines require the use of anatomical modifiers to describe applicable procedures at the highest level of specificity. Providers must align rendered and reported services by appending applicable anatomical modifier(s) to procedures involving fingers, toes, eyes, coronary arteries, and paired organs or structures, to help ensure accurate reimbursement.

Modifier	Description
E1	Upper left eyelid
E2	Lower left eyelid
E3	Upper right eyelid
E4	Lower right eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
50	Bilateral procedure
LT	Left side (identifies procedures performed on the left side of the body)
RT	Right side (identifies procedures performed on the right side of the body)
50	Bilateral procedure (identifies procedures performed on both sides of the body)
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LM	Left main coronary artery
RC	Right coronary artery
RI	Ramus intermedius
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

Definitions

Bilateral procedure
The same procedure performed on both the left and the right side of a patient’s body during the same operative session or on the same day.

Modifier
A modifier is a 2-digit indicator used in conjunction with a CPT code to denote that a service or procedure that has been performed has been altered by a circumstance without changing the definition of the CPT code.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)
VI. District of Columbia Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0006.5420 Bilateral Procedures

Policy History

12/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by Healthy DC from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section