PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_051749

Title	**Site Specifying Modifiers**		
Number	**CP.PP.092.v3.2**		
Last Approval Date	01/08/25	**Original Effective Date**	05/16/00
Replaces			
Cross Reference	• *Durable Medical Equipment (DME)/Home Medical Equipment (HME)* • *Modifier 50- Bilateral Procedure* • *Multiple Surgical Reductions*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose

To define when the Plan recognizes the use of Site Specifying Modifiers that are submitted on a CMS 1500 paper claim or 837P electronic claim form.

Scope

Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.

Policy

The Plan recognizes site-specifying modifiers appended to a procedure code to indicate that a procedure was performed on the same patient at specific anatomical sites.

Per the current Healthcare Common Procedure Coding System (HCPCS) Level II code file, site specifying modifiers include:

- **Eyelid Modifiers**:
  - E1 – Upper left eyelid
  - E2 – Lower left eyelid
  - E3 – Upper right eyelid
  - E4 – Lower right eyelid
- **Finger Modifiers**:
  - 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
  - FA - Left hand, thumb
- LC: Left circumflex coronary artery
- LD: Left anterior descending coronary artery
- LM: Left main coronary artery
- RC: Right coronary artery
- RI: Ramus intermedius coronary artery
- RT: Right
- LT: Left
- **Toe Modifiers**:
  - T1 – Left foot, second digit
  - T2 - Left foot, third digit
  - T3 - Left foot, fourth digit

	o T4 - Left foot, fifth digit o T5 – Right foot, great toe o T6 - Right foot, second digit o T7 - Right foot, third digit o T8 - Right foot, fourth digit o T9 - Right foot, fifth digit o TA - Left foot, great toe Only one site-specifying modifier should be appended to an applicable procedure code (CPT/HCPCS), for example: • 67800-E1 – Excision of chalazion, single; Upper left eyelid • 67800-E2 – Excision of chalazion, single; Lower left eyelid **Laterality** Laterality as identified by the LT or RT modifiers on the procedure code should match the laterality identified on the International Classification of Diseases (ICD)-10 CM diagnosis code. Per the ICD-10-CM Official Guidelines for Coding and Reporting, some ICD-10-CM diagnosis codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral diagnosis code exists and the condition is bilateral, assign separate diagnosis codes for both the left and right side. Conflicts between the laterality of the diagnosis code and the laterality of the procedure code, as defined by the site specifying modifiers, will result in non-reimbursement. Modifiers LT and RT are not used to indicate a bilateral surgical procedure. Modifier 50 - *Bilateral Procedure* should be used to represent **a bilateral procedure when performed on identical anatomic locations** unless the procedure code description is inherently bilateral or unilateral. Modifiers LT and RT apply to procedure codes which can be performed on paired organs or identical anatomic locations such as, but not limited to, eyes, ears, nostrils, kidney, lungs, arms, legs or ovaries. Modifiers LT or RT should be used when a procedure is performed on **only one anatomic side**. Procedures performed on the eyelids, fingers or toes should use one of the appropriate modifiers noted above rather than modifiers LT or RT unless the procedure is not related to the eyelids, fingers or toes. All second and subsequent surgical procedures with these modifiers will be subject to reimbursement adjustments for bilateral procedures and/or multiple surgical reductions when applicable. Modifiers that affect reimbursement should be billed first and site specifying modifiers should be billed in the subsequent modifier positions.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion.

	Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None
References	• Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Level II Codes • American Medical Association Current Procedural Terminology (AMA/CPT) Codebook • International Classification of Diseases (ICD-10-CM) Official Guidelines for Coding and Reporting

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	01/08/25; 03/04/24; 04/06/23; 01/17/23; 02/10/22; 02/25/21; 03/05/20; 03/15/19; 04/19/18; 07/18/17; 08/08/16; 08/10/15; 08/10/14; 08/15/13; 08/19/12; 08/29/11; 09/03/10; 11/22/09; 12/19/08; 12/20/07; 11/24/06; 08/29/05; 04/12/05; 10/08/04; 04/14/04; 04/24/03; 05/16/00	
Version History	04/19/18	Provided clarification on the correct usage of Modifiers LT and RT in the "Policy" section
	03/15/19	Annual review; no changes
	03/05/20	Annual review; no changes
	02/25/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms. Listed the Eyelid, Finger and Toe individual modifiers. Added last paragraph in the Policy section to indicate reimbursement modifiers should be billed in the primary position and all other modifiers subsequently.
	02/10/22	Clarified that left and right modifiers must match the laterality of the ICD-10 CM diagnosis code and that the left and right modifiers are appended only when the procedure pertains to one anatomic side but not both.
	01/17/23	Created a new section in the Policy for Laterality
	04/06/23	Added a paragraph after the list of site specifying modifiers indicating that only one site specifying modifier should be appended to a procedure code.
	03/04/24	In the Laterality section, added the sixth paragraph to describe the correct criteria to bill bilateral surgical procedures and to describe the correct selection of the related diagnosis code to reflect a bilateral diagnosis code if one is present for the diagnosis category.
	01/08/25	In the Laterality sub-section, a duplicative paragraph was deleted.