Code Editing Policy & Guidelines

For Health Care Professionals

February 2014



Current Procedure Terminology (CPT®) codes, Health Care Procedure Coding System (HCPCS) codes, and modifiers are used to represent services provided and procedures performed. Correct coding, including appending modifiers appropriately, enables accurate identification of the submitted service or procedure and leads to more efficient claim processing. The guidelines in this document are not all-inclusive.

To view additional information, please log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Claim Editing Policies & Procedures).

ClaimCheck and ClaimsXten

ClaimCheck® is an automated code auditing tool developed by McKesson that we use to help expedite and improve the accuracy of processing claims for services provided by health care professionals.

Effective February 17, 2014, we will begin using ClaimsXtenTM, a new clinical code editing software also developed by McKesson, for medical and behavioral products. ClaimsXten will facilitate accurate claim processing for medical and behavioral claims submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 claim form. ClaimsXten code auditing is based on assumptions regarding the most common clinical scenarios for services performed by a health care professional for the same patient. ClaimsXten logic is based upon a thorough review by physicians of current clinical practices, specialty society guidance, and industry standard coding.

As part of our upgrade to ClaimsXten, 22 new code editing rules will go into effect. These 22 new code editing rules are detailed below in the Policy Section of this document and are designated as "new CXT rules." Additionally, please note that the majority of our code edits that are now in ClaimCheck version 10 will continue to apply with no change when they migrate as part of our upgrade to ClaimsXten on February 17, 2014.

New code edits and National Correct Coding Initiative (NCCI) edits will be applied to CPT and HCPCS codes introduced every January.

In addition, updates to coding guidelines and NCCI edits will be applied on a guarterly basis with the use of the new ClaimsXten code editing software.

- On August 19, 2013, our ClaimCheck software was updated to Knowledge Base Version 51 and NCCI Version 19.1 Column 1/Column 2 edits for all medical and behavioral claims we process.
- On February 17, 2014, the new ClaimsXten software will include ClaimCheck Knowledge Base Version 52 content and NCCI Version 20.0 Column 1/Column 2 edits for all medical and behavioral claims we process.

Appropriate modifiers must be appended to service codes to indicate that significant, separately identifiable services were performed outside of the most common clinical scenario. All services provided should be fully documented by office or operative notes and provided to us upon request or as specified in our Reimbursement and Modifier Policies.

Services considered incidental or mutually exclusive to the primary service rendered, or as part of a global allowance, are not eligible for separate reimbursement. Patients covered under Cigna-administered plans should not be balance billed for clinically edited non-paid services.

Definitions

Definitions	
Frequency Edits	Many procedures are limited to a specified number of times they may be performed per date of service. McKesson Frequency Edits are developed based on the CPT/HCPCS code description, anatomic considerations, CPT instructions, CMS policies, nature of service or procedure, nature of analyte, nature of equipment, and clinical judgment or clinical feasibility. Frequency edits disallow procedures exceeding the maximum number of times they may be performed per date of service.
	We are aligned with CMS Medically Unlikely Edits for frequency limitations. When CMS has no frequency designation for a procedure or service, we default to McKesson frequency edits for that procedure or item.
Global Allowance	Reimbursement for certain services is based on pre- and post-operative global allowance established by the CMS. Claims for services considered directly related to a procedure's global allowance are considered integral to that service and will not be separately reimbursed.
	Minor surgical procedures have either a zero- or ten-day post-operative global period. Major surgical procedures have a one-day pre-operative and 90-day post-operative period for medical visits. Follow-up office visits during the post-operative period are included in the procedure's global allowance and will not be separately reimbursed.
	Note: Submit the CPT/HCPCS code only once and without a modifier to report the global value of the service. A frequency edit will occur on many codes if they are reported more than once for the same date of service.
Incidental Procedure Edits	A procedure that is performed at the same time as a more complex primary procedure, requiring little additional physician resources and/or is clinically integral to the performance of the primary procedure, is considered incidental to the related primary procedure(s) on the same date of service and will not be separately reimbursed.
Mutually Exclusive Procedure Edits	Mutually exclusive procedures are two or more procedures that are not usually performed during the same patient encounter on the same date of service. Generally, an open procedure and a closed procedure in the same anatomic site will not be separately reimbursed. If both procedures achieve the same result, only one will be reimbursed; most often the more clinically intense procedure.
National Correct Coding Initiative (NCCI) Column One/Column	The CMS established the National Correct Coding Initiative (NCCI) program to ensure the correct coding of services. The NCCI edits are also known as Column 1/Column 2 or Procedure to Procedure (PTP) edits.
Two Edits	NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a column 1 and column 2 HCPCS/CPT code and a Correct Coding Modifier Indicator (CCMI).
	If a health care professional reports the two codes of an edit pair for the same beneficiary on the same date of service and the CCMI is 0, the column 2 code is denied, and the column 1 code is eligible for payment.
	If the CCMI is 1 and an NCCI-associated modifier is used because the appropriate clinical circumstances are met, the NCCI edit will be bypassed and the column 2 code will be considered for payment. If the CCMI is 1 and an NCCI-associated modifier is not used, the column 2 code is denied.
Rebundling Procedure Edits	Procedure unbundling occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code is available. ClaimsXten rebundles the single procedure codes to the comprehensive CPT/HCPCS code. ClaimsXten will add the comprehensive code if a procedure code that more accurately represents the service exists but is not included on the claim.
	The CMS designate certain procedures to be "always bundled into payment for other services not specified." These procedures have a status code indicator of "B" on the CMS National Physician Fee Schedule Relative Value File. These procedures will be edited as of February 2014 by the ClaimsXten Bundled Service Rule, defined in Policies below.

Policies

The information presented in this document is not all-inclusive. To view the policies, please log in to the Cigna for Health Care Professionals website (<u>CignaforHCP.com</u> > Useful Links > Policies and Procedures).

Cigna modifier or Reimbursement policy	Description and information
Add-On Code Without Base Code and Add-On Code	Add-On codes are CPT and HCPCS-defined codes that are to be billed in addition to a primary code during a session. An Add-On code cannot be billed as a stand-alone code. The AMA has assigned specific base codes for most add-on codes.
Without Base Code 2 (new CXT rules)	The Add-On Without Base Code Rule recommends the denial of claim lines containing an add-on code where there is an AMA-defined base code which has not also been reported for the same customer and health care professional on the same date of service.
	The Add-On Without Base Code 2 Rule recommends the denial of claim lines containing an add- on code where a base code has not also been reported for the same customer and health care professional on the same date of service.
	The add-on codes contained in this rule do not have specific base codes defined for them in CPT or HCPCS. The add-on code has been associated with the specific CPT category of services to which the base code would belong.
After-Hours Care	We support physicians' efforts to treat patients in the office setting rather than refer them to emergent or urgent care. Accordingly, separate reimbursement is allowed for after-hours CPT codes 99050 when billed with one of the E/M codes from the following list: 99201-99205, 99212-99215, 99241-99245, and 99354-99355.
	In addition, separate reimbursement is allowed for after-hours code 99058 when billed with one of the E/M codes from the following list: 99201-99205 and 99212-99215.
	Please Note: Separate reimbursement for the after-hours CPT Codes 99050 and 99058 is allowed on claims where only the after-hours code and its associated E/M code (see lists above) are billed. Adding additional codes to the claim may alter the payment of the after-hours code.
	After-hours services represented by CPT codes 99051–99056 and 99060 do not support physicians treating patients in the office. Separate reimbursement for these services is not allowed. A modifier will not override the edit.
Anesthesia Crosswalk (new CXT rule)	In alignment with AMA/CPT coding guidelines, Anesthesia Health Care Professionals are to bill for anesthesia services by reporting the CPT code for anesthesia administration, and not the CPT code representing the surgical services.
	The American Society of Anesthesiologists (ASA) Crosswalk Table converts CPT procedure codes to anesthesia codes as appropriate when a claim for anesthesia services, as identified by health care professional type, specialty, or identification number, is submitted with other than a designated anesthesia code.
	The ASA Anesthesia Standard Crosswalk Rule identifies procedure codes for non-anesthesia services submitted by an Anesthesiology Health Care Professional that have a one-to-one relationship with anesthesia services as identified by the ASA. The Rule will replace that procedure with the appropriate anesthesia procedure code as specified in the ASA Crosswalk Table and the crosswalked code will be considered for payment.
Anesthesia Crosswalk 2	Many non-anesthesia CPT codes often describe procedures that may be done in a variety of anatomic regions, while anesthesia CPT codes are specific to both procedure and region.
(new CXT rule)	The ASA Anesthesia Multiple Crosswalk Rule will find claim lines submitted by an Anesthesiology Health Care Professional, with a non-anesthesia CPT code that has a one-to-many relationship with an anesthesia code. Unless documentation is provided with the initial claim, the non-anesthesia CPT code will be disallowed, as the appropriate anesthesia crosswalk cannot be determined. The claim may be resubmitted with the appropriate anesthesia code.

Cigna modifier or Reimbursement policy	Description and information	
Anesthesia Not Eligible (new CXT rule)	The ASA Crosswalk Table converts CPT procedure codes to anesthesia codes as appropriate when a claim for anesthesia services, as identified by health care professional type, specialty, or identification number, is submitted with other than a designated anesthesia code.	
	The ASA Anesthesia Not Eligible Rule will disallow claim lines submitted by Anesthesia Health Care Professionals for non-anesthesia procedure codes that are not eligible to be crosswalked to an anesthesia procedure code.	
	According to the American Society of Anesthesiologists (ASA), certain codes cannot be crosswalked for one of the following reasons: it is not a primary procedure code, anesthesia care is not normally required, it is a radiology service related to a diagnostic or therapeutic service, or it is a non-specific unlisted procedure code.	
Assistant Surgeons and Assistants-at- Surgery	Assistant Surgeon (modifiers 80, 81, 82) and Assistant-at-Surgery (modifier AS) are processed per CMS designations to Allow or Not Allow.	
	CMS Assistant Surgeon / Assistant-at-Surgery designations of "2" are allowed without documentation.	
	Effective February 17, 2014, CMS Assistant Surgeon / Assistant-at-Surgery designations of "0" will require documentation with the initial claim submission.	
	For more details, please see Reimbursement Policy #MAS (Modifiers 62, 66, 80, 81, 82 and AS) on the secure Cigna for Health Care Professionals website (<u>CignaforHCP.com</u> > Useful Links > Policies and Procedures > Claim Editing Policies and Procedures).	
Base Code Quantity (new CXT rule)	Certain CPT procedure codes are used to report a primary service/procedure, or base code, which are only appropriately billed once per date of service. CPT provides add-on codes to report additional services associated with the primary or base procedure.	
	When billing a base code procedure, additional services beyond the primary service/procedure should be billed with an appropriate add-on code. Quantities of base code greater than one will be disallowed and replaced with a new line with the same procedure code and quantity equal to one.	
Bundled Service (new CXT rule)	Certain procedure codes are designated by CMS as "bundled" by a status code indicator of "B" on the CMS National Physician Fee Schedule Relative Value File. When billed with any other procedure code that is not indicated as a "bundled" service, these procedures are considered a component of, or incident to, the overall service provided, and separate reimbursement is not warranted.	
Chemotherapy	Chemotherapy administration service processing follows CMS guidelines. Evaluation and Management (E/M) services are typically disallowed when submitted on the same date of service as a chemotherapy administration code (CPT codes 96401-96417). You can append Modifier 25 to the E/M service code if a significant, separately identifiable service is performed.	
	Note: Chemotherapy administration codes have been valued to include the work and practice expenses of CPT code 99211. A modifier may not override this edit.	
	Note: For a few specified code combinations, supporting documentation must be submitted with the initial claim in addition to appending modifier 25 to the E/M, or the edit will remain and the office visit disallowed. For additional information, please view the Modifier 25 information below and refer to the Modifier 25 Policy.	
Colonoscopy	Colonoscopies performed proximal to the splenic flexure (CPT codes 45380, 45383, 45384, and 45385) are considered part of the same family of endoscopic procedures. The biopsy of one or more lesions, as described in CPT code 45380, is considered integral to the more clinically intense multiple lesion removal and will not be separately reimbursed.	
	Modifier 59 Exception Scenario: In the event that a biopsy of a lesion (CPT code 45380) is performed on a separate and distinct lesion from the lesion removal, you should append Modifier 59 to CPT code 45380.	
	In the event that a separate and distinct lesion(s) is removed via different surgical techniques such as with a snare or hot biopsy forceps, you should append Modifier 59 to CPT codes 45384 or 45385 as appropriate.	

Cigna modifier or Reimbursement policy	Description and information		
Component Billed (new CXT rule)	The CMS National Physician Fee Schedule Relative Value file directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures.		
	If a professional or technical component of a procedure is submitted and the same global procedure was previously submitted by the same provider ID for the same customer for the same of service, the component service will not be additionally reimbursed.		
Computer-assisted Stereotactic	We follow CPT/CPT Assistant direction for coding edits associated with CPT Codes 61781, 61782, and 61783. The CPT direction is as follows:		
Navigational Procedures for	Do not report 61781 in conjunction with codes 61720-61791, 61796-61799, 61863-61868, 62201, 77371-77373, or 77432.		
Cranial and Spinal Procedures	 Do not report 61781 and 61782 by the same health care professional during the same surgical session. 		
	Do not report 61783 in conjunction with 63620 or 63621. Do not report 61783 in conjunction with 63620 or 63621. Do not report 61783 in conjunction with 63620 or 63621.		
	 Do not report 61781-61783 in conjunction with 20660. Do not report 61796-61799 in conjunction with 61781-61783. 		
Computer-assisted Surgical Navigational Procedures For Musculoskeletal	For any code pair not listed above, we follow NCCI PTP edits. Separate reimbursement is not provided for Computer-Assisted Surgical Navigational Procedure for Musculoskeletal Procedures (CPT codes 20985, 0054T, and 0055T) as it is considered incidental to the primary overall service.		
Procedures			
Co-Surgeon Modifier 62	This rule identifies claim lines containing procedure codes billed with the co-surgery modifier (62) that have or have not met the criteria for co-surgery payment according to CMS.		
(new CXT rule)	Please Note: Supporting documentation for the need of a co-surgeon is required for CMS Co-Surgeon Designation # 1 on initial claim submission.		
Deleted Code (new CXT rule)	This rule recommends the denial of claim lines containing deleted procedure codes when submitted after the deletion date of the procedure code. The health care professional is required to submit a corrected claim with the code that is valid for the date of service.		
Developmental Screening	Separate reimbursement is allowed for developmental screening (CPT code 96110) when submitted with problem-based (CPT codes 99201-99215) and preventive E/M office visits (CPT codes 99381-99397).		
Electrical Stimulation Electrodes	The supply of electrodes is considered incidental to electrical stimulation. Separate reimbursement for incidental supplies is not allowed.		
Electrocardiograms	Electrocardiograms (ECG) (e.g., CPT codes 93000, 93005, 93010) will not be separately reimbursed when submitted with a cardiac stress test (CPT code 93015), a cardiac test that includes an ECG as part of the test, or with initial hospital care. A three-lead ECG is considered incidental to a 12-lead ECG. Separate reimbursement for ECGs that are considered incidental is not allowed. An ECG is considered mutually exclusive to physician services for cardiac rehabilitation (CPT code 93797). Separate reimbursement for ECGs that are considered mutually exclusive is not allowed.		
	Separate reimbursement for the interpretation of an ECG report (CPT code 93010) will be allowed once for the report officially attached to the EKG. Separate reimbursement is not allowed for 93010 when submitted with the following services: emergency room E/M (CPT codes 99281-99285); or critical care E/M (CPT codes 99291-99292). Interpretation of the ECG report by the attending physician is considered part of the E/M visit.		
Fetal Non-Stress	We reimburse for more than one fetal non-stress test performed on the same date of service		
Test 59025	when the test is being performed on more than one fetus in a multiple gestation situation. The		
3 3 023	diagnosis on the claim must reflect the multiple gestation. See the list of eligible diagnoses below: 651.00 651.03 651.10 651.13 651.20 651.23 651.30		
	651.33 651.40 651.43 651.50 651.53 651.60 651.63		
	651.80 651.83 651.90 651.93		

Cigna modifier or Reimbursement policy	Description and information
Global Component (new CXT rule)	The CMS National Physician Fee Schedule Relative Value file directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures. A single health care professional can bill for both components (global procedure), or different health care professionals can each bill for different components. Claims for these types of procedures are paid up to the total of the global procedure (both technical and professional components combined). Any submission of the same procedure will be evaluated against previous submissions to determine if any or all components of the procedure have already been paid and the claim will be adjusted accordingly.
	If a global procedure is billed on a current line or support line without modifier –26 or –TC present in any modifier fields, and the claim facility flag = Y, the technical component (–TC) will be assumed.
	If a global procedure is billed on the current line without modifier –26 or –TC present in any modifier fields, and the claim facility flag = N, and the Place of Service (POS) is Inpatient or Outpatient, the professional component (–26) will be assumed on the current line.
	Note: if either –TC or –26 have been paid in history, and a global procedure is reported (either a current claim line reported with both modifiers –TC and –26, or a claim line reported without any modifiers but with a facility flag of N and a POS not inpatient or outpatient) on the current claim line, the global component will be denied. A claim line will be added with the appropriate component to prevent overpayment.
Global Obstetrics (OB) (new CXT rule)	This rule audits potential overpayments for obstetric care. It will evaluate claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery and postpartum services were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy and postpartum period as applicable. Please view the #R11 Global Maternity/Obstetric Package policy on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures >
Immunization Administration Codes	Modifiers and Reimbursement Policies) A frequency edit applies to charges submitted for CPT code 90460 exceeding nine units and 90461 exceeding seven units per date of service.
90460 and 90461 Inpatient Consultations (new CXT rule)	A consultation is a type of service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. Furthermore, [If] subsequent to the completion of the consultation, the consultant assumes responsibility for the management of a portion or all of the patient's condition[s], the appropriate Evaluation and Management (E&M) service code for the site of service should be reported.
	An inpatient consultation for the customer, for the same diagnosis, within the five days following an inpatient consultation will be disallowed. The follow up service should be billed with a non-consultation CPT E&M code for the appropriate level of office visit, established patient or subsequent hospital care.
Knee Arthroscopy Procedures	We apply NCCI PTP coding edits to knee arthroscopy procedures. CPT codes 29874 and 29877 should not be reported with other knee arthroscopy codes (CPT codes 29866-29889) and a modifier will not override the NCCI edit. HCPCS code G0289 must be used to report arthroscopies performed in the secondary or tertiary compartments of the same knee at the same time as the primary knee arthroscopy procedure.
	G0289 is denied as incidental to codes 29880 and 29881. Modifier 59 will override the edit. Documentation supporting the use of Modifier 59 must be provided to us upon request.

Cigna modifier or Reimbursement policy	Description and information		
Laboratory Tests	When all tests described as included in laboratory panel are performed on a single patient, the laboratory panel code should be reported. If reported separately, the individual laboratory codes will be re-bundled into the appropriate panel code for reimbursement. Individual laboratory codes that constitute a panel are considered mutually exclusive to the laboratory panel code. Laboratory services that are billed with Modifier 26 and have a CMS PC/TC indicator of 3		
Medically Unlikely	(Technical Component Only) or 9 (PC/TC Concept Not Applicable) will be denied. The Medically Unlikely Edit (MUE) Rule applies frequency limitations as defined by CMS. These		
Edit (new CXT rule)	edits were developed by CMS based on anatomic considerations, HCPCS/CPT code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment. This rule will disallow payment for non-facility claim services exceeding the MUE value for a CPT/HCPCS code across all claim lines by the same health care professional, for the same customer, on the same date of service.		
	We are aligned with CMS Medically Unlikely Edits for frequency limitations. When CMS has no frequency designation for a procedure/service, Cigna we default to McKesson frequency edits for that procedure.		
Missing Modifier 26 (new CXT rule)	This rule recommends the denial of claim lines containing a procedure code submitted without a professional component modifier-26 in a facility setting (POS 21, 22, or 24). The Centers for Medicare and Medicaid Services (CMS) guidelines establish that certain procedures performed in certain settings require billing of the professional component modifier. These codes are identified in the National Physician Fee Schedule Relative Value File.		
Modifier Processing and Documentation Requirements	We process CMS/NCCI PTP procedure code edits, as well as apply CMS/NCCI modifier override designations. CMS/NCCI establishes when a modifier may override a coding edit by assigning one of the following designations: 0 = not allowed 1 = allowed 9 = not applicable		
	CMS requires that complete and accurate supporting documentation be maintained and submitted upon request for audit/review. We require documentation for a specific subset of edits CMS/NCCI designates as "1."		
Modifier 25	 Modifier 25 may be used to indicate a problem-based E/M office visit (CPT codes 99201-99215) that is significant and separately identifiable from a preventive office visit (CPT codes 99381-99397) on the same date of service. If Modifier 25 is appended correctly, both services are separately reimbursable. Modifier 25 must be appended to the disallowed E/M office visit. Please view Clear Claim Connection™ to learn which of the two E/M services is disallowed. Documentation is not required to override the edit for problem-based and preventive office 		
Modifier 25	visits on the same date of service. Please follow the steps below for any code combination on the Modifier 25 Documentation		
Documentation Requirement	Requirement List: • Append Modifier 25 to the disallowed E/M service code if both services should be considered for reimbursement. • Documentation must be submitted with the claim and must indicate the patient's condition was significant enough to: • satisfy the key component criteria for the level of the E/M service as defined by the CMS 1997 Documentation Guidelines for Evaluation and Management Services®, and • warrant a separately identifiable E/M service on the same day as the a reported procedure; or • exceed the usual pre-operative and post-operative care included in the procedure reported on that date. (See Global Allowance). • If Modifier 25 is not appended to the disallowed code and/or documentation is not indicated as attached, the CMS/NCCI edit will remain in place, and the service will be disallowed. Supporting documentation is required on 57 code combinations, which is approximately 1% of claims submitted with a Modifier 25. To view the list of code combinations, please log in to the		

Cigna modifier or Reimbursement policy	Description and information		
		na for Health Care Professionals website (<u>CignaforHCP.com</u> > Useful Links > Policies dures > Claim Editing Policies and Procedures).	
Modifier 59 Documentation Requirement	Please follow the steps below for any code combination on the Modifier 59 Documentation Requirement List: • Do not use Modifier 59 with E/M service codes. • Append Modifier 59 to the disallowed service code. • Submit documentation with the claim indicating why the procedure, service, or clinical scenario should be considered distinct from the primary procedure or service. • If you do not append Modifier 59 to the disallowed code and submit documentation, the CMS/NCCI edit will remain in place and the service will be disallowed.		
	List. For detection the entire Care Profession Editing Po	t 19, 2013, 49 code pairs were added to the Modifier 59 Documentation Requirement etails on the August list update, please see the August Code Edit Bulletin. Or, to view list of code combinations requiring documentation, go to the secure Cigna for Health essionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Claim licies and Procedures).	
Modifier SL (state supplied vaccine)	to the hea \$0.01. Ple	reimburse state supplied vaccines. If the vaccine was supplied by the state at no cost th care professional, please append Modifier SL to the CPT vaccine code and bill ase report the vaccine administration service code (90460-90474) separately. Please and modifier SL to the vaccine administration code.	
Modifier to Procedure Validation (new CXT rule)	Modifiers provide a way to indicate that a service or procedure that has been performed has be altered by a specific circumstance. Certain procedures can be reported with a modifier that all payment for services otherwise bundled, due to additional significant, separately identifiable services. We will not allow separate reimbursement for services reported with specific "payment affecting" modifiers if the modifier is not appropriate for the procedure code billed. When multimodifiers are submitted on a line, all are evaluated and if at least one is found invalid with the procedure code, the line will be recommended for denial. Modifiers edited by this rule:		
	Modifier	Description	
	22	Increased Procedural Services	
	24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	
	25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service	
	26	Professional Component (Laboratory services that are billed with Modifier 26 and have a CMS PC/TC indicator of 3 (Technical Component Only) or 9 (PC/TC Concept Not Applicable) will be denied.)	
	27	Multiple Outpatient Hospital E/M Encounters on the Same Date	
	33	Preventive Service	
	50	Bilateral Procedure	
	51	Multiple Procedures	
	52	Reduced Services Discontinued Procedure	
	53 54	Surgical Care Only	
	55	Postoperative Management Only	
	56	Preoperative Management Only	
	57	Decision for Surgery	
	58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	
	59	Distinct Procedural Service	
	62	Two Surgeons	
	66	Surgical Team	
	73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	

Cigna modifier or Reimbursement policy	Description and information		
	74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	
	76	Repeat Procedure or Service by Same Physician	
	78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period	
	79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period	
	80	Assistant Surgeon	
	81	Minimum Assistant Surgeon	
	82	Assistant Surgeon (when qualified resident surgeon not available)	
	91	Repeat Clinical Diagnostic Laboratory Test	
	AA	Anesthesia Services Performed Personally by Anesthesiologist	
		(Anesthesia health care professionals should be utilizing CPT designated anesthesia codes with an appropriate anesthesia modifier)	
	AD	Medical Supervision by a Physician: More than 4 Concurrent Anesthesia Procedures	
	AR	Physician Provider Services in a Physician Scarcity Area	
	AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery	
	QB	Physician Providing Service in a Rural HPSA	
	QK	Medical Direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals	
	QU	Physician Providing Service in an Urban HPSA	
	QW	CLIA Waved Test	
	0)/	(Lab codes valid with this modifier are aligned with CMS CLIA Waived Test list)	
	QY	Medical Direction of One Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist	
	QZ	CRNA Service: Without Medical Direction by a Physician	
	TC QX	Technical Component CRNA Service: With Medical Direction by a Physician	
Multiple Births	<u> </u>	a Multiple Births Reimbursement Policy is based on recommendations from the	
	American coding an Profession and Reim	College of Obstetricians and Gynecologists (ACOG). For additional information and d modifier guidance, please view the policy on the secure Cigna for Health Care nals website (CignaforHCP.com > Useful Links > Policies and Procedures > Modifiers bursement Policies > R03 – Multiple Births).	
Multiple Radiology Reduction; Contiguous Body	We reimburse radiology services performed in adjacent or contiguous body areas per CMS guidelines. Specific information is available in the "Cigna Multiple Radiology Reduction - Contiguous Body Parts Reimbursement Policy."		
Areas	The highest allowable reimbursement amount for covered services is paid at 100% of the fee schedule amount, maximum reimbursable charge (MRC), or usual and customary (U&C) rate (as applicable), while all subsequent procedures are subject to the multiple radiology reduction and will be reimbursed at 50% of the technical component of the fee schedule, MRC, or U&C rate (as applicable).		
National Correct Coding Initiative (NCCI)	We apply CMS National Correct Coding Initiative (NCCI) edits to all CMS 1500 claims. The NCCI edits are known as Column 1/Column 2 or Procedure to Procedure (PTP) edits. We also have a reimbursement policy for facilities consistent with NCCI edits which applies to all facility claims, or any portion of a facility claim, paid based upon billed charges or a percentage of billed charges on the UB04 form. NCCI edits are available on the CMS website.		
	Cigna for Procedure	onal information and coding and modifier guidance, please view the policy on the secure Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and es > Modifiers and Reimbursement Policies).	
Never Events and Avoidable Hospital Conditions		ot reimburse services identified as avoidable or should never occur, consistent with our ment policy for Never Events and Avoidable Hospital Conditions.	
(new CXT rule)		ew the policy on the Cigna for Health Care Professionals website (CignaforHCP.com > ks > Policies and Procedures > Never Events Fact Sheet).	

Cigna modifier or Reimbursement policy	Description and information	
Never Event - Related Service (new CXT rule)	Services billed on the same date as a never event including hospitalizations and other services related to the never event procedures will not be reimbursed, consistent with our reimbursement policy for Never Events and Avoidable Hospital Conditions.	
	Please view the policy on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Modifiers and Reimbursement Policies).	
New Patient Evaluation & Management Code (new CXT rule)	This rule recommends the denial of claim lines containing a new patient E&M code when another claim line containing any E&M code was billed by the same health care professional within a three-year period. The new patient code will be replaced with the appropriate established patient code.	
Outpatient Consultations (new CXT rule)	A consultation is a type of service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. Furthermore, [If] subsequent to the completion of the consultation, the consultant assumes responsibility for the management of a portion or all of the patient's condition[s], the appropriate Evaluation and Management (E&M) service code for the site of service should be reported.	
	An outpatient consultation for the customer, for the same diagnosis, within 180 days following a previously submitted outpatient consultation will be disallowed. The follow up service should be billed with a non-consultation CPT E&M code for the appropriate level of office visit, established patient or subsequent hospital care.	
Office Visits	Office visit CPT code 99211 is not usually separately reimbursed when submitted with CPT codes 95115-95117 (allergen immunotherapy). An E/M service code should be reported with the allergen immunotherapy codes only if a significant separately identifiable E/M service is performed.	
Operating Microscope	We follow the CMS Medicare Claims Processing Manual, which limits reporting the use of an operating microscope, CPT code 69990 with CPT codes 61304-64907. An edit will disallow the operating microscope if CPT code 69990 is reported with other codes. Modifiers will not override most of these edits.	
Post-operative Continuous Local Delivery of Analgesia	Note: CPT guidelines for reporting CPT code 69990 differ from CMS guidelines. Reimbursement for pain pump infusion catheter insertion for the continuous local infusion of analgesia is included in the primary surgical procedure(s) and not eligible for separate reimbursement. For additional details, please see Reimbursement Policy R06 "Post-operative Continuous Local Delivery of Analgesia."	
Pulse Oximetry	CPT codes 94760-94762 are considered incidental to the overall service provided and separate reimbursement is not allowed. A modifier will not override the edit. These procedure codes are identified by CMS as status 'T' codes, and will be edited by the new CXT T Status Codes Rule as not payable when billed on the same date of service as any procedure payable under the physician fee schedule (defined as status A and R codes) for the same customer and same health care professional.	
Qualitative Drug	Effective August 19, 2013, we aligned with CMS in requiring the use of either G0431 or G0434 for the billing of qualitative drug screens. Both codes G0431 and G0434 will be eligible for one (1) unit of reimbursement per date of service.	
	Codes 80100, 80101, and 80104 will no longer be eligible for reimbursement; charges associated with these codes will be denied.	
Radiology	When single view and double view chest x-rays are billed together (CPT codes 71010 and 71020), only the double view x-ray is allowed. When a single view x-ray code is billed with a multiple view x-ray code, only the multiple view x-ray code is allowed (e.g., submitting CPT code 72020 with 72040, 72070, or 72100). Only one professional and one technical component are allowable per x-ray.	
Respiratory Treatment	Demonstration or evaluation of patient use of an aerosol generator, nebulizer, metered dose inhaler, or IPPB device (CPT code 94664) is considered mutually exclusive to an office visit.	
Robotic Surgical Systems	Additional reimbursement is not provided for the robotic surgical technique (HCPCS code S2900). Reimbursement is based on the treatment provided rather than the technology involved in the procedure.	

Cigna modifier or Reimbursement policy	Description and information
Screening Papanicolaou Smear Q0091	A Screening Pap Smear (HCPCS code Q0091) and/or the Cervical or Vaginal Cancer Screening (G0101) is considered part of a preventive or problem based office visit and is not separately reimbursable. The screening services of Q0091 and/or G0101 are considered for separate reimbursement when reported in addition to a significant and separately identifiable E/M service.
Cervical or vaginal cancer screening; pelvic and clinical	Modifier 25 must be appended to the E/M service for the screening services to be separately reimbursed. Documentation supporting the unrelated E/M service meeting the Modifier 25 requirements must be maintained and made available to us upon request.
breast examination G0101	Exception: Q0091 and G0101 are components of a Preventive Medicine E/M Service and will not be separately reimbursed. Modifier 25 appended to the Preventive Medicine E/M CPT Codes will not override the edit (Preventive Medicine E/M CPT codes 99381- 99397).
Specimen Handling / Conveyance Update	Charges for the handling or conveyance of a specimen or device (CPT 99000, 99001, and 99002) are not separately reimbursable. A modifier will not override this edit.
Surgical Supplies	Surgical supplies (CPT code 99070) are considered incidental to all surgical, laboratory, inpatient medical E/M, and consultation services. Miscellaneous surgical supplies (HCPCS code A4649) are considered incidental to all medical, chemotherapy, surgery, and radiology services, including those performed in the office setting.
Surgical Trays	Separate reimbursement is allowed for surgical trays (A4550) when submitted with the following CPT service codes: 28297 – 28299; 32000; 37609; 38500; 43200; 43220; 43226; 43234-43235; 43239; 43247; 43250-43251; 43458; 45378-43580; 45382-45385; 49080-49081; 51720; 52000; 52007; 52010; 52204-52260; 52270-52281; 52283; 52290 -52310; 53020; 54057-54060; 54100; 54700; 55250; 57520; 58120; 62270; 96440; 96445; 96450.
	Please Note: Separate reimbursement for a surgical tray (A4550) is allowed on claims where only A4550 and the surgical CPT code that qualifies for a surgical tray (see list above) are billed. Adding additional codes to the claim may alter the payment of the surgical tray.
T-Status Codes (new CXT rule)	This rule identifies claim lines containing T status procedure codes which are not payable when billed on the same date of service as any procedure payable under the physician fee schedule or other allowed amount (defined as status A and R codes) for the same customer and same health care professional.
Team Surgeon Modifier 66 (new CXT rule)	This rule identifies claim lines containing procedure codes billed with the team surgery Modifier 66 that have or have not met the criteria for team surgeon payment according to CMS.
,	Please Note: Supporting documentation listing the need for a team surgery is required for a CMS Team Surgery Designation of 1 on the initial claim submission.
Unlisted Special Services	An unlisted special service, procedure, or report (CPT code 99199) is considered incidental to all other services and will not be separately reimbursed.
Urgent Care Services S9088	Additional reimbursement is not allowed for HCPCS code S9088 - Services provided in an urgent center (list in addition to code for service). This code is considered incidental to the primary service(s) performed.
Vital Capacity	Vital capacity (CPT code 94150) is considered incidental to the overall service provided, whether an office visit or a procedure, and will not be separately reimbursed.





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