Health Care Professionals

PROFESSIONAL CLAIMS
CODE EDITING AND DOCUMENTATION REQUIREMENTS GUIDELINES

Updated April 22, 2009

Professional outpatient services are identified by submitting Current Procedure Terminology (CPT®) codes or Health Care Procedure Coding System (HCPCS) codes. These codes and CPT and HCPCS code 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 Introduction section of the *CPT 2009 Professional Edition* manual (page xiv) contains the following statement:

> Inclusion in the CPT codebook does not represent endorsement by the American Medical Association (AMA) of any particular diagnostic or therapeutic procedure. Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.

ClaimCheck® code auditing is based on the assumption of the most common clinical scenario performed by the same provider for the same patient on the same date of service. Appropriate modifiers must be appended to service codes to indicate that the clinical scenario was not common. All services provided should be fully documented by office or operative notes and provided to CIGNA upon request or as specified in CIGNA 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. Individuals with CIGNA coverage should not be billed for services considered Mutually Exclusive, Incidental, or integral to the primary service.

All Reimbursement and Modifier Policies are available on the secure CIGNA for Healthcare Professionals website at www.cignaforhcp.com. To view, click on 'Resources > Modifiers and Reimbursement Policies'.

Definitions

■ **Incidental Procedure Edits -** An incidental procedure is carried out at the same time as a more complex primary procedure. In these scenarios, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. For these reasons, an Incidental procedure is not reimbursed separately. Procedures considered incidental when billed with related primary procedures on the same date of service will be disallowed for reimbursement.

■ **Global Allowance -** Reimbursement for certain services is based on pre- and post-operative global allowance established by the Centers for Medicare and Medicaid Services (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 time period are included in the procedure's global allowance and will not be separately reimbursed.

■ **Mutually Exclusive Procedure Edits -** Mutually exclusive procedures are two or more procedures that are usually not 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 clinically more intense procedure.

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■ **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. ClaimCheck rebundles the single procedure codes to the comprehensive CPT/HCPCS code. ClaimCheck will add the comprehensive code if a procedure code that most accurately represents the service exists but is not included on the claim.

Policies

The guidelines presented in this document are not all-inclusive.

■ **2009 New code edits -** CPT and HCPCS ClaimCheck edits are effective as of January 1, 2009.

■ **After-Hours Care –** CIGNA supports 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 and 99058. After-hours services represented by CPT codes 99051 – 99056 and 99060 do not support physicians' treating patients in the office. Separate reimbursement is not allowed for these services.

■ **Assistant Surgeons and Assistants-at-Surgery** – Beginning April 20, 2009 Assistant Surgeons (modifiers 80, 81, 82) and Assistants-at-Surgery (modifier AS) will be processed per CMS designations to *Allow* or *Not Allow*. CMS Assistant Surgeon / Assistant-at-Surgery designations of "2" will be allowed without documentation. Additional information is available in the *Assistant Surgeon / Assistant-at-Surgery Reimbursement Policy*.

■ **Balloon Sinuplasty** – Nasal / sinus endoscopy HCPCS code S2344 is Mutually Exclusive to CPT codes 31256, 31276 or 31287 (nasal / sinus endoscopy). See the *Balloon Sinuplasty Reimbursement Policy* for more information.

■ **Chemotherapy –** Beginning April 20, 2009, chemotherapy administration service processing will follow CMS guidelines. Evaluation and Management (E/M) services are generally disallowed when submitted on the same date of service as a chemotherapy administration code (CPT 96401 - 96417). Append modifier 25 to the E/M service code if a significant, separately identifiable service is performed. Supporting documentation must be submitted, or the edit will remain and the service will be disallowed. See the Modifier 25 bullet below and refer to the *Modifier 25 Policy* for additional information.

■ **Colonoscopy** – Colonoscopies performed proximal to the splenic flexure (CPT 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 45380, is considered a component of (integral to) the more clinically intense multiple lesion removal and does not merit separate reimbursement. Modifier 59 may be appended if a distinct procedural service unrelated to the primary procedure was performed.

■ **Developmental Testing –** Developmental testing (CPT 96110) denies as incidental to preventive E/M office visits (CPT 99381 – 99397). Modifier 59 may be appended to 96110 to indicate a distinct procedural service, if appropriate. CIGNA will also reimburse 96110 separately if modifier 25 is appended to the preventive E/M service code.

■ **Electrical Stimulation Electrodes** - The supply of electrodes is considered incidental to electrical stimulation. Separate reimbursement is not allowed for incidental supplies.

■ **Electrocardiograms** - Electrocardiograms (ECG) (i.e., CPT 93000, 93005, 93010) will not be separately reimbursed when submitted with a cardiac stress test (CPT 93015), with 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 is not allowed for ECGs that are considered incidental. An ECG is considered Mutually Exclusive to physician services for cardiac rehabilitation (CPT 93797). Separate reimbursement is not allowed for ECGs that are considered Mutually Exclusive.

■ **Electrocardiograms** – Separate reimbursement for the interpretation of an ECG report (CPT 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: initial hospital care E/M (CPT 99222 – 99223); emergency room E/M (CPT 99281 – 99285); or critical care E/M (CPT 99291 – 99292). Interpretation of the ECG report by the attending physician is considered part of the E/M visit.

■ **Laboratory Tests** – When all tests described as included in laboratory panel (CPT 80048-80076) are performed on a single patient, the laboratory panel code should be reported. If reported separately, the individual laboratory codes will be

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rebundled into the appropriate panel code for reimbursement. Individual laboratory codes that constitute a panel are considered Mutually Exclusive to the laboratory panel code.

■ Modifier Processing and Documentation Requirements – Beginning April 20, 2009, CIGNA will process CMS/NCCI Incidental and Mutually Exclusive procedure code edits. Along with this expanded system capability, CIGNA will 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**. In an effort to address an increased use of modifier 25 and of modifier 59, CIGNA will require documentation for a specific subset of edits CMS/NCCI designates as '1':**

Modifier 25: The current supporting documentation requirement for modifier 25 is being temporarily required from April 20, 2009 – April 26, 2009. Beginning April 27, the modifier 25 policy supporting documentation requirements will be significantly reduced. Supporting documentation will be required on 73 code combinations, approximately 1% of claims submitted with a modifier 25. The updated code combination lists will be available online prior to April 27. To view, log in to the secure CIGNA for Health Care Professionals website at www.cignaforhcp.com and click on 'Resources > Claim Editing Procedures'.

Modifier 59: The supporting documentation requirement for modifier 59 is being delayed until April 27, 2009. Beginning April 27, the modifier 59 policy supporting documentation requirements will be significantly reduced. Supporting documentation will be required on 121 code combinations, approximately 2% of claims submitted with a modifier 59. The updated code combination lists will be available online prior to April 27. To view, log in to the secure CIGNA for Health Care Professionals website at www.cignaforhcp.com and click on 'Resources > Claim Editing Procedures'.

CIGNA specifically identified two edit types with two modifiers (*CMS/NCCI Incidental edits with modifier 25* and *CMS Mutually Exclusive edits with modifier 59*) to target the edits identified as having the highest modifier use increases from 2007 through 2008.

Electronic Claim Submissions - Claims with edits that require documentation may be submitted electronically. Indicate on the electronic claim form in Box 19/Loop 3200 that an attachment (documentation) is being sent and the claim will continue to process. The indicators on the electronic claim include the delivery method for sending the attachment (i.e., fax, mail), as well as a description code for the type of attachment (e.g., physician's report, operative notes). Supporting documentation can be faxed to CIGNA at 1.570.496.2945 or sent via mail to the CIGNA address on the back of the patient's ID card. Claims processing time will not be extended by indicating a document is attached.

Paper Claim Submissions - Paper claims processing time will not be extended by supporting documentation submission.

■ Modifier 25 - Evaluation & Management (E/M) service codes that disallow with a CMS/NCCI Incidental Edit (also called Column 1/Column 2 Code Edits) designated by CMS as '1' requires supporting documentation for some specific code combinations.

- Append modifier 25 to the disallowed E/M service code if both services should be considered for reimbursement.
- A list of the code combinations requiring documentation is provided in the Modifier 25 CMS/NCCI Incidental Edit Code List.
- Documentation must indicate the patient's condition was significant enough to:
  • 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 (electronically in box 19/Loop 3200) or submitted with the claim (paper), the CMS/NCCI Incidental edit will remain in place and the service will be disallowed.
- Refer to the CIGNA *Modifier 25 Policy* for more detailed information.

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■ **Modifier 25** - Modifier 25 may be used to indicate a problem-based E/M office visit (CPT 99201-99215) is significant and separately identifiable from a preventive office visit (CPT 99381-99397) on the same date of service. If modifier 25 is appended correctly, both services are separately reimbursable. Additional information is available in the CIGNA Reimbursement Policy *E/M, Office and Other Outpatient Services Billed on the Same Day by the Same Physician with Preventive Medicine Evaluation and Management Services*.

- Modifier 25 must be appended to the disallowed E/M office visit.
- View Clear Claim Connection to learn which of the two E/M services is disallowed.
- ***Documentation is not required to override the edit between problem-based and preventive office visits.***

■ **Modifier 59** - **Non-Evaluation & Management (E/M) service codes that disallow with a CMS/NCCI Mutually Exclusive Edit designated by CMS as '1' requires supporting documentation for some specific code combinations.**

- Modifier 59 is not appropriate for use with E/M service codes.
- Append modifier 59 to the disallowed service code.
- A list of code combinations that require documentation is provided in the Modifier 59 CMS/NCCI Mutually Exclusive Edit Code List.
- Documentation must indicate why the procedure, service or clinical scenario should be considered distinct from the primary procedure or service.
- If modifier 59 is not appended to the disallowed code ***and/or*** documentation is not indicated as attached (electronically, Box 19/Loop 3200) or submitted with the claim (paper), the CMS/NCCI Mutually Exclusive edit will remain in place and the service will be disallowed.
- Refer to the *Modifier 59 Policy* for more detailed information.

■ **Modifier SL (State supplied vaccine) -** CIGNA does not reimburse state supplied vaccines. If vaccine was supplied by the state at no cost to the health care professional, append modifier SL to the CPT vaccine code and bill $0.00. Code the vaccine administration service code (90465 - 90474) separately. Do not append modifier SL to the vaccine administration code.

■ **Multiple Births –** The CIGNA *Multiple Births Reimbursement Po*licy is based on recommendations from the American College of Obstetricians and Gynecologists (ACOG). View the policy for additional information and coding and modifier guidance.

■ **Multiple Radiology Reduction; Contiguous Body Areas –** CIGNA reimburses 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*.

■ **National Correct Coding Initiative (NCCI) –** As of April 20, 2009 CIGNA will apply CMS/NCCI Incidental and Mutually Exclusive edits to all professional claims. The NCCI edits are available on the CMS website at http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp.

■ **Never Events and Avoidable Hospital Conditions -** CIGNA will not reimburse services that are identified as avoidable and/or should never occur. For additional information, view the *Never Events and Avoidable Hospital Conditions Reimbursement Policy*.

■ **Office Visits -** Office visit CPT 99211 is not separately reimbursed when submitted with CPT codes 95115-95117 (allergen immunotherapy).

■ **Post-operative Continuous Local Delivery of Analgesia –** 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. Refer to the *Reimbursement Policy* of the same name.

■ **Pulse Oximetry** - Pulse oximetry (CPT 94760 – 94762) is considered incidental to the overall service provided, whether an office visit or procedure. Separate reimbursement is not allowed.

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■ **Respiratory Treatment** - Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB devise (CPT 94664) is considered mutually exclusive to an office visit. Separate reimbursement is not provided for Mutually Exclusive services.

■ **Robotic Surgical Systems** - Additional reimbursement is not provided for the robotic surgical technique, (HCPCS S2900). Reimbursement for new technology is based on the outcome of the treatment rather than the technology involved in the procedure. View the *Robotic Assisted Surgery Reimbursement Policy* for additional information.

■ **Screening Papanicolaou Smear** - The screening Pap smear (HCPCS Q0091) is considered part of a preventive or problem-based office visit and is not separately reimbursable. Modifier 25 will not override the NCCI Incidental edit and allow this service when submitted with either a routine or preventative office visit.

■ **Specimen Handling / Conveyance** - The handling or conveyance of a specimen from a physician's office to a laboratory (CPT 99000) is not separately reimbursable.

■ **Surgical Supplies -** Surgical supplies (CPT 99070) are considered incidental to all surgical, laboratory, inpatient medical E/M, and consultation services. Miscellaneous surgical supplies (HCPCS 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; 43247; 43250 – 43251; 43458; 45378 – 43580; 43582 – 43585; 49080 – 49081; 51720; 52000; 52007; 52010; 52204 – 52260l 52270 – 52281; 52283; 52290 – 52310; 52320; 54057 – 54060; 54100; 54700; 55250; 57520; 58120; 62270; 85095; 85102; 96440; 96445; 96450.

■ **Therapeutic Injections –** Office visits (CPT 99201 - 99215; 99381 - 99397) will not be separately reimbursed when submitted with therapeutic injections (CPT 90772-deleted for 2009; replacement code is 96372). Append modifier 25 to the disallowed E/M code if a significant separately identifiable E/M service was performed.

■ **Transvaginal Ultrasound** - Transvaginal ultrasound (CPT 76830) is considered mutually exclusive to a hysterosonography with or without color flow Doppler (CPT 76831).

■ **Ultrasonic Guidance** – Transrectal ultrasound (CPT 76872) is considered mutually exclusive to ultrasonic guidance for needle placement (CPT 76942) for the same session and the same anatomic site. CPT guidelines state an ultrasonic guidance procedure is understood to include imaging protocols comparable to diagnostic ultrasound. Therefore, in anatomic regions of small dimension where needle guidance imaging requires assessment of the entire tissue volume, separately reporting the diagnostic component during the same clinical session is considered a fundamental overlap of services.

The American Urology Association guidelines recognize that CPT 76872 may be performed to determine if further biopsy (CPT, 76942) is required. In this scenario modifier 59 should be appended to indicate a separate and distinct procedure. Note that supporting documentation must be submitted for both services to be considered for separate reimbursement.

■ **Unlisted Special Services** - An unlisted special service, procedure, or report (CPT 99199) is considered incidental to all other services and will not be separately reimbursed.

■ **Visual Acuity Testing** – CPT code 99173, visual acuity screening test, is separately reimbursable when submitted with preventive office visits (CPT 99381 – 99397).

■ **Vital Capacity** - Vital capacity (CPT 94150) is considered incidental to the overall service provided, whether an office visit or a procedure, and will not be separately reimbursement.

■ **X-Rays -** When single view and double view chest X-rays are billed together (CPT 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 72020 with 72040, 72070, or 72100). Only one professional and one technical component are allowable per X-ray.

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Policy History / Updates

Date	Change / Update
4/20/09	Document title changed to *Professional Claims Code Editing and Documentation Requirements Guidelines*. (Original title: *Code Editing and Documentation Requirements Guidelines*.) Revised modifier 25 and modifier 59 bullet points with additional clarifying points about the documentation requirements initially posted 1/20/09. Added statement that code lists specifying the code combinations/edits for each that require supporting documentation are posted on the secure website cignaforhcp.com. Added policy statement that CPT code 99000 is not separately reimbursable. Added policy statement that HCPCS code Q0091 submitted with an E/M office visit is not separately reimbursable. Note, modifier 25 will not override the NCCI Incidental edit and allow service. Added modifier SL policy statement. State supplied vaccines are not reimbursable.
1/20/09	Initial policy. Posted on the secure website cignaforhcp.com and internally on the CPU intranet site ClaimCheck page.

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