August 2013

Code Edit Policy and Guidelines
For Health Care Professionals

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®
ClaimCheck is an automated code auditing tool developed by McKesson that we use for all medical products to help expedite and improve the accuracy of processing claims for services provided by health care professionals. ClaimCheck logic is based upon a thorough review by physicians of current clinical practices, specialty society guidance, and industry standard coding.

New Code Edits, National Correct Coding Initiative (NCCI) Incidental and Mutually Exclusive edits, will be applied to CPT and HCPCS codes introduced annually every January.

- On August19, 2013, our ClaimCheck software was updated to Knowledge Base Version 51 and NCCI Version 19.1 Column 1/Column 2 (incidental) and Mutually Exclusive code edits for all medical claims processed by Cigna.

We use ClaimCheck to facilitate accurate claim processing for medical claims submitted to us on a HCFA 1500 claim form. ClaimCheck code auditing is based on the assumption of the most common clinical scenario performed by a health care professional 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 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 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. Patients covered under Cigna-administered plans should not be billed for services considered mutually exclusive, incidental, or integral to the primary service.

General reminders and updates
As a reminder, certain code combinations require supporting documentation when either Modifier 25 or 59 is billed. The code pair lists are available online in the Modifier 25 and Modifier 59 policies.

On August 19, 2013, 49 code pairs will be added to the Modifier 59 Documentation Requirement List. Additionally, in order to be eligible for separate reimbursement, health care professionals who bill both services on a claim will be required to send supporting documentation with the claim. The documentation should support that the services were separate and distinct from each other and thus warrant separate reimbursement. For more details on these updates, please see the Modifier 59 Documentation Requirement summary outlined on page four. For the complete code pair listing, please see the Modifier 59 Reimbursement Policy located on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Claim Editing Policies and Procedures > Modifier 59 Code Editing List).

Claims should continue to be submitted electronically to us, even if supporting documentation is required. Please indicate in the PWK (Claim Supplemental Information) segment of Loop 2300 of the electronic claim that the documentation will be sent through another channel.

The indicators on the electronic claim include the delivery method (PWK02) for sending the attachment (e.g., fax, mail), as well as the description code (PWK01) for the type of attachment (e.g., physician report, operative notes). The attachment indicators or a text reference to an attachment should not be placed in the NTE (Claim Note) segment of Loop 2300 of the electronic claim. We will not recognize that attachments were sent if the indicator or other attachment reference is sent in the NTE segment of Loop 2300 of the electronic claim. Please work with your electronic data interchange (EDI) vendor to ensure the correct fields on the electronic claim are completed.

Supporting documentation can be faxed to us at 1.859.410.2422 or sent by mail to the Cigna address on the back of the patient's ID card.

Definitions

Duplicate Procedure Edits	Many procedures are limited to a specified number of times they may be performed per date of service, either by the CPT/HCPCS code description, or by clinical feasibility. Separate reimbursement will not be allowed for procedures exceeding the maximum number of times they may be performed per date of service.
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 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 duplicate edit will occur on many codes if they are reported more than once for the same date of service. Appending a modifier to one of the codes does not override the duplicate edit.
Incidental Procedure Edits	If an incidental procedure is performed at the same time as a more complex primary procedure, and the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure when billed with related primary procedures on the same date of service 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.
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 more accurately represents the service exists but is not included on the claim.

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 (CignaforHCP.com > Useful Links > Policies and Procedures).

Cigna modifier or Reimbursement policy	Description and information
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.
Assistant Surgeons and Assistants-at-Surgery	Assistant Surgeons (modifiers 80, 81, 82) and Assistants-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 July 1, 2011, physicians billing for assistant surgeon services (Modifier 80 and 82) are reimbursed 16% of the fee schedule or usual and customary/maximum reimbursable charge. Please see "Reimbursement Policy Assistant Surgeon – Modifiers 80, 81, 82, Assistant-at-Surgery – Modifier AS" for more details.
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

<table>
<tr><th>Cigna modifier or Reimbursement policy</th><th>Description and information</th></tr>
<tr><td></td><td>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.</td></tr>
<tr><td>Colonoscopy</td><td>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.</td></tr>
<tr><td>Computer-assisted Stereotactic Navigational Procedures for Cranial and Spinal Procedures</td><td>Effective May 21, 2012, we follow CPT/CPT Assistant direction for coding edits associated with CPT Codes 61781, 61782, and 61783. The CPT direction is as follows:
Do not report 61781 in conjunction with codes 61720-61791, 61796-61799, 61863-61868, 62201, 77371-77373, or 77432.
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 61781-61783 in conjunction with 20660.
Do not report 61796-61799 in conjunction with 61781-61783.
For any code pair not listed above, we follow NCCI Incidental and Mutually Exclusive edits.</td></tr>
<tr><td>Computer-assisted Surgical Navigational Procedures For Musculoskeletal Procedures</td><td>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.</td></tr>
<tr><td>Developmental Screening</td><td>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).</td></tr>
<tr><td>Electrical Stimulation Electrodes</td><td>The supply of electrodes is considered incidental to electrical stimulation. Separate reimbursement for incidental supplies is not allowed.</td></tr>
<tr><td>Electrocardiograms</td><td>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.</td></tr>
<tr><td>Fetal Non-Stress Test 59025</td><td>Effective October 17, 2011, we will consider more than one fetal non-stress test performed on the same date of service when the test is being performed on more than one fetus in a multiple gestation situation. The diagnosis on the claim must reflect the multiple gestation. See the list of eligible diagnoses below:
<table>
<tr><td>651.00</td><td>651.03</td><td>651.10</td><td>651.13</td><td>651.20</td><td>651.23</td><td>651.30</td></tr>
<tr><td>651.33</td><td>651.40</td><td>651.43</td><td>651.50</td><td>651.53</td><td>651.60</td><td>651.63</td></tr>
<tr><td>651.80</td><td>651.83</td><td>651.90</td><td>651.93</td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Immunization Administration Codes 90460 and 90461</td><td>Effective May 23, 2011, a daily maximum limit of nine units for CPT code 90460 and five units for 90461 will be assigned. A duplicate procedure edit will apply to charges submitted for CPT code 90460 exceeding nine units and 90461 exceeding five units per date of service. Effective February 20, 2012, the daily maximum limit for CPT Code 90461 will increase to seven. The daily maximum limit for CPT Code 90460 will remain at nine units.</td></tr>
</table>

Cigna modifier or Reimbursement policy	Description and information
Knee Arthroscopy Procedures **Update**	We apply NCCI coding rules 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 incidental 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. Effective May 21, 2012, G0289 will be denied as incidental to codes 29880 and 29881. A modifier will not override the edit. Effective May 20, 2013, modifier 59 will override the edit. Documentation supporting the use of Modifier 59 must be provided to us upon request.
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.
Modifier Processing and Documentation Requirements	We process CMS/NCCI Incidental and Mutually Exclusive 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 visits on the same date of service.
Modifier 25 Documentation Requirement.	Please follow the steps below for any code combination on the Modifier 25 Documentation 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: o 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 Incidental 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 secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > 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 Mutually Exclusive edit will remain in place and the service will be disallowed.

Cigna modifier or Reimbursement policy	Description and information
	On August 19, 2013, 49 code pairs will be added to the Modifier 59 Documentation Requirement List. For details on the August list update, please see the August Code Edit Bulletin. Or, to view the entire list of code combinations requiring documentation, go to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Claim Editing Policies and Procedures).
Modifier SL (state supplied vaccine)	We do not reimburse state supplied vaccines. If the vaccine was supplied by the state at no cost to the health care professional, please append Modifier SL to the CPT vaccine code and bill $0.01. Please report the vaccine administration service code (90460-90474) separately. Please do not append modifier SL to the vaccine administration code.
Multiple Births	The Cigna Multiple Births Reimbursement Policy is based on recommendations from the American College of Obstetricians and Gynecologists (ACOG). For additional information and coding and modifier guidance, please view the policy on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Modifiers and Reimbursement Policies > R03 – Multiple Births).
Multiple Radiology Reduction; Contiguous Body Areas	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." The Multiple Radiology Reduction - Contiguous Body Part Reimbursement Policy was updated on July 1, 2011, to reflect a reduction to the current reimbursement rate. The highest allowable reimbursement amount for covered services is now 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 will be 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)	As of April 20, 2009, we apply CMS/NCCI Incidental and Mutually Exclusive edits to all professional claims. The NCCI edits are available on the CMS website.
Never Events and Avoidable Hospital Conditions	We will not reimburse services identified as avoidable or should never occur, consistent with our reimbursement policy for Never Events and Avoidable Hospital Conditions. Please view the policy on the Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Never Events Fact Sheet).
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, per the *Current Procedure Terminology (CPT) 2011 Professional Edition* (page 493).
Operating Microscope	We follow the CMS Medicare Claims Processing Manual, which limits reporting the use of an operating microscope, CPT code 69990, to CPT codes 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, and 64905-64907. An edit will disallow the operating microscope if CPT code 69990 is reported with other codes. Modifiers will not override most of these edits. Note: CPT guidelines for reporting CPT code 69990 differ from CMS guidelines.
Physical Medicine and Rehabilitation	We follow NCCI Mutually Exclusive coding rules for CPT Code pair 97012 and 97140. If Modifier 59 criteria are met for 97012 and 97140, you should append Modifier 59 to CPT code 97140 and both codes will be reimbursed separately. Documentation supporting the use of Modifier 59 must be available to us upon request.
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. For additional details, please see Reimbursement Policy R06 "Post-operative Continuous Local Delivery of Analgesia."
Pulse Oximetry	CPT codes 94760-94762 is considered incidental to the overall service provided and separate reimbursement is not allowed. A modifier will not override the edit.
Qualitative Drug Screens	Effective August 19, 2013, we will align 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

Cigna modifier or Reimbursement policy	Description and information
	component are allowable per x-ray.
Respiratory Treatment	Demonstration or evaluation of patient use of an aerosol generator, nebulizer, metered dose inhaler, or IPPB devise (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.
Screening Papanicolaou Smear Q0091 **Cervical or vaginal cancer screening; pelvic and clinical breast examination G0101**	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. As of February 21, 2011, 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. 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. Exception: Q0091 and G0101 will remain a component 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.
Therapeutic Injections	Office visits (CPT codes 99201-99205; 99212-99215; 99381-99397) will not be separately reimbursed when submitted with therapeutic injections (CPT code 96372). Please append Modifier 25 to the disallowed E/M code if a significant separately identifiable E/M service was performed. Note: CPT code 96372 has been valued to include the work and practice expenses of CPT code 99211. A modifier will not override this edit.
Transvaginal Ultrasound	Transvaginal ultrasound (CPT code 76830) is considered mutually exclusive to a hysterosonography with or without color flow Doppler (CPT code 76831).
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	Effective October 17, 2011, additional reimbursement will not be 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.
Visual Acuity Testing	CPT code 99173, visual acuity screening test, is separately reimbursable when submitted with preventive office visits (CPT codes 99381-99397).
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.

Policy history and updates

Date	Update
08/19/2013	Removed range of codes from Laboratory Test section. Added clarification to surgical tray section..
05/15/2013	Addition of 49 code pairs being added to the Modifier 59 Documentation Requirement List and addition of Qualitative Drug Screens Reimbursement Policy, effective August 19, 2013.
02/11/2013	Updated ClaimCheck and NCCI Version Information, effective May 20, 2013. Removed Balloon Sinuplasty as S2344 is a deleted code. Reimbursement Policy R07 Balloon Sinuplasty remains. Added

	modifier override change for code G0289. Included codes 99001 and 99002 to the Conveyance/Handling policy statement.
11/20/2012	Updated ClaimCheck and NCCI Version Information effective February 18, 2013. Added policy pathway for Multiple Births and Never Events Reimbursement Policies.
07/22/2012	Updated NCCI Version information, effective October 22, 2012.
04/20/2012	Updated ClaimCheck and NCCI Version information, effective May 21, 2012. Clarification of the After-Hours Care Code edit. Added information regarding Computer-assisted Stereotactic Navigational Procedures for Cranial and Spinal Procedures effective May 21, 2012. Updated change in edit for code G0289 effective May 21, 2012.
02/20/2012	Updated the daily maximum limit for CPT Code 90461. Updated the reference to CPT Code 96110 as developmental screening rather than developmental testing as the CPT description changed for year 2012.
11/20/2011	Removed May 2011 ClaimCheck Release information
10/3/2011	Updated ClaimCheck and NCCI version information effective February 20, 2012.
7/17/2011	Updated with details on Fetal Non-Stress Test and Urgent Care Services policy guidelines. Deleted Ultrasonic Guidance section, as edit no longer exists.
5/16/2011	Updated NCCI version information, effective October 17, 2011. Added the updated reimbursement information for Modifies 80 and 82 and Multiple Radiology Reduction, effective July 1, 2011.
2/21/2011	Updated ClaimCheck and NCCI version information, effective May 23, 2011. Removed Modifier 59 Exception scenario for Pulse Oximetry. Added new 2011 CPT Codes related to Balloon Sinuplasty policy. Added information about code pair 97012 and 97140. Changed Title of section from “XRays” to “Radiology” and moved section to appropriate location. Changed Title of Document to Code Edit Policy. Added maximum daily limits for codes 90460/90461.
11/10/2010	Updated with additional information about the reduction of code combinations requiring supporting documentation for Modifier 59 and Modifier 25. Updated ClaimCheck and NCCI version information, effective February 21 2011. Added policy statement that 20985, 0054T and 0055T are not separately reimbursable. Added 43239 and removed deleted codes 85095 and 85102 to the surgical tray list. Added Modifier 59 Exception scenario for Pulse Oximetry and Colonoscopy. Updated coding edit for G0101 and Q0091, effective February 21, 2011 for non Preventative E/M visits.
7/12/2010	Updated ClaimCheck and NCCI version information, effective July 19, 2010.
4/15/2010	Updated with additional information about the reduction of code combinations requiring supporting documentation for Modifier 59. Updated ClaimCheck and NCCI version information, effective May 17, 2010. Updated ClaimCheck and NCCI version information, effective July 19, 2010.
2/5/2010	Updated with additional information about supporting documentation requirements for modifier 25 and 59.
12/3/2009	Added note about submitting for global services. Added note that modifiers do not override edits with non-eligible After-Hours codes. Added allowed office codes to Developmental Testing. Added CPT 99211 may not be separately reimbursable with many chemotherapy, therapeutic, or vaccine administration codes. Added Knee Arthroscopy coding guidance. Added direction about E/M code level submissions and supporting documentation.
4/20/2009	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 that was initially posted January 20, 2009. 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.
1/20/2009	Initial policy. Posted on the secure website, CignaforHCP.com.