

A guide to **CIGNA'S PREVENTIVE HEALTH COVERAGE** for health care professionals



Introduction

Cigna's preventive care coverage complies with the Patient Protection and Affordable Care Act (PPACA). Services designated as preventive care include periodic well visits, routine immunizations and certain designated screenings for symptom-free or disease-free individuals. Preventive care services also generally include additional immunization and screening services for symptom-free or disease-free individuals at increased risk for a particular disease.

The PPACA requires health plans to cover preventive care services with no patient cost-sharing, unless the plan qualifies under the grandfather provision or for an exemption. The majority of Cigna plans fall under the PPACA, and cover the full cost of preventive care services, including copay and coinsurance. Typically, these services must be provided by in-network health care professionals. There are some exceptions.

To determine whether or not your patient's Cigna-administered plan covers preventive care and at what coverage level (100% or patient cost share), visit the Cigna for Health Care Professionals website (CignaforHCP.com) to verify benefit and eligibility information, or call **1.800.88Cigna (882.4462)**. For patients with a GWH-Cigna ID card, visit the GWH-Cigna Secured Provider Portal (GWHCignaforHCP.com), or call **1.866.494.2111**.

Preventive care services

The PPACA has designated specific resources that identify the preventive services required for coverage by the act.

- U.S. Preventive Services Task Force (USPSTF) A and B recommendations.
- Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control. Recommendations of the ACIP appear in four immunization schedules.
- Comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
 - Guidelines for infants, children and adolescents appear in two charts: the periodicity schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.
 - Guidelines specifically issued for women that became effective as applicable for health plans upon inception or renewal on or after August 1, 2012.
- In addition, Cigna covers prostate cancer screening and virtual colonoscopy for colorectal cancer screening as covered preventive services.

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For more information regarding the preventive recommendations of these resources and implementation of the PPACA regulations, please see the federal government website: Healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

Coding for preventive services

Correctly coding preventive care services is key to receiving accurate payment for those services.

- Preventive care services must be submitted with an ICD-9 code that represents health services encounters that are not for the treatment of illness or injury. The ICD-9 code must be placed in the first diagnosis position of the claim form (see the list of designated “V codes” in the following table for each preventive service). This guide will include ICD-10 codes when updated later this year in preparation for ICD-10 in 2014.
- If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service will not be identified as preventive care and your patients’ claims will be paid using their normal medical benefits rather than preventive care coverage.
- Use CPT coding designated as “Preventive Medicine Evaluation and Management Services” to differentiate preventive services from problem-oriented evaluation and management office visits (99381–99397, 99461, 99401–99404, S0610, S0612). Non-preventive care services incorrectly coded as “Preventive Medicine Evaluation and Management Services” will not be covered as preventive care.

When to use modifier 33: preventive service modifier

Modifier 33 was developed by the industry in response to the preventive service requirements associated with the PPACA. When the primary purpose of providing a service is evidence-based in accordance with a U.S. Preventive Services Task Force A or B rating, or other preventive services identified in preventive services mandates (legislative or regulatory), that specific service may be identified as preventive by appending modifier 33, preventive service, to the procedure code.

Note that Cigna claim systems are not yet configured to process preventive service claims solely based on the presence of modifier 33. It is required that the service also be submitted with a well-person diagnosis code as indicated. We will notify you when our claim systems can accept and recognize modifier 33.

Screening versus diagnostic, monitoring or surveillance testing

A positive result on a preventive screening exam does not alter the classification of that service as a preventive service.

One example is a screening colonoscopy that is performed on an asymptomatic individual, who has not been diagnosed with the target condition of colorectal cancer or additional risk factors for colorectal cancer, such as adenomatous polyps, or inflammatory bowel disease. If the screening colonoscopy detects colorectal cancer or polyps, the purpose of the colonoscopy remains as preventive screening and is considered a screening colonoscopy, not a diagnostic colonoscopy. In order for Cigna to pay this service accurately as a preventive service, with no cost share required by your patient, the diagnosis and procedure codes submitted on the claim must represent a screening colonoscopy, as indicated on page eight of the following coding table. However, once a diagnosis of colorectal cancer or additional risk factors for colorectal cancer are identified, future colonoscopies will no longer be considered preventive screening, but are considered monitoring or surveillance of a diagnosed condition. Typically monitoring/surveillance services are provided more frequently than the routine screening frequency which is 10 years for colonoscopy.





As another example, a bone density screening exam is performed on an asymptomatic woman who has not been diagnosed with osteoporosis. If the bone density screening exam results in a diagnosis of osteoporosis, the purpose of this initial bone density screening exam remains a screening exam, not a diagnostic test. The bone density screening exam should be submitted on the claim form with a designated diagnosis code in the first position, and procedure codes which represent bone density screening exam, as indicated on page nine of the following coding table. However, future bone density exams after the osteoporosis diagnosis is identified, will not be considered preventive screening, but are considered disease monitoring or surveillance of a diagnosed condition.

Services associated with a screening colonoscopy

Ancillary services directly related to a screening colonoscopy are considered preventive services. Therefore, the pre-procedure evaluation office visit with the physician who will perform the colonoscopy, as well as the ambulatory facility fee, anesthesiology (if necessary) and pathology services will be considered and reimbursed to your patient as preventive services providing the claim is submitted using the diagnosis and procedure codes for a preventive colonoscopy.

Payment of preventive services

Payment of preventive services by Cigna is dependent on claim submission using diagnosis and procedure codes which identify the services as preventive. The coding guidance on the following pages will assist you and your billing staff.

The following pages reflect the PPACA designated clinical recommendations and the associated ICD-9, CPT and HCPCS codes. Age and frequency limits of these recommendations are not utilized for reimbursement with the exception of vision and hearing screening, administration of HPV vaccines, and services related to prevention of falls. All standard correct coding practices should be observed.

Additional information about preventive care guidelines is available in the health care professionals section of Cigna's Informed on Reform website: **InformedonReform.com**.

This information does not supersede the specific terms of an individual's health coverage plan, or replace the clinical judgment of the treating physician with respect to appropriate and necessary care for a particular patient.

References

International Classification of Diseases, 9th Revision, Copyright © 2012, Practice Management Information Corporation
Current Procedural Terminology (CPT®) 2012, American Medical Association

<p style="text-align: center;">Preventive coverage</p>	<p>ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)</p>	<p>CPT codes/ HCPCS codes (represent the services listed)</p>
<p>Comprehensive preventive evaluation and management services (preventive office visits for well baby, well child and well adult, including well woman)</p> <p>The frequency of visits for infants, children and adolescents complies with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule, which can be located on the Department of Health and Human Services website, accessible via InformedonReform.com.</p> <p>Comprehensive preventive medicine evaluation and management of an individual includes:</p> <ul style="list-style-type: none"> • An age- and gender-appropriate history • Physical examination • Counseling/anticipatory guidance • Risk factor reduction interventions and • The ordering of appropriate immunization(s) and laboratory/screening procedures <p>See the following pages for the specific preventive laboratory screenings. Lab screenings not listed in this reference guide will not be covered at the preventive benefit level of reimbursement.</p> <p>These preventive evaluation and management (E&M) services are represented by distinct CPT codes from those that represent problem-oriented evaluation and management services.</p> <ul style="list-style-type: none"> • Preventive initial E&M (new patient) (CPT codes 99381–99387) • Preventive periodic E&M (established patient) (CPT codes 99391–99397) <p><i>Note that codes 99381–99397 include counseling, anticipatory guidance and risk factor reduction interventions that are provided at the time of the initial or periodic comprehensive preventive medicine examination.</i></p>	<p>V20.0, V20.1, V20.2, V20.3, V20.31, V20.32</p> <p>V65.11</p> <p>V70.0, V70.8, V70.9, V72.3, V72.31, V79.0, V79.1, V79.3, V79.8, V79.9</p>	<p>99381–99387 (new patient)</p> <p>99391–99397 (established patient)</p> <p>99461 (initial newborn care)</p> <p>S0610 } S0612 } annual GYN exam S0613 }</p> <p>99420 (administration of HRA)</p> <p>G0402, G0438, G0439 (Medicare only)</p>

<p style="text-align: center;">Preventive coverage</p>	<p>ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)</p>	<p>CPT codes/ HCPCS codes (represent the services listed)</p>
<p>Comprehensive preventive evaluation and management services <i>(continued)</i></p> <p>Typically, the examination component of the preventive evaluation and management service includes, but is not limited to:</p> <ul style="list-style-type: none"> • Age- and gender-appropriate review of physical condition, including vital signs such as blood pressure, height/weight/BMI calculation (utilized to screen for obesity) • Review of family and personal health risks • Screening (not examination) of vision and hearing status • Screening for growth and development milestones and developmental surveillance • Autism screening • Psychosocial/behavioral assessment • Screening for depression in adolescents and adults • Screening for alcohol and substance misuse/abuse • Screening for tobacco use <p>Typically, the counseling/anticipatory guidance/risk factor reduction component of the preventive evaluation and management service includes, but is not limited to:</p> <ul style="list-style-type: none"> • Oral health (including water fluoridation discussion and referral to dental home) • Counseling regarding obesity, weight loss, healthy diet and exercise • Breast-feeding counseling and support • Counseling and evaluation for BRCA testing (see page 9 for additional services related to genetic testing) • Discussion of chemoprevention with women at high risk for breast cancer • Counseling related to sexual behavior/STD/STI prevention • Aspirin prophylaxis for cardiovascular risk • Guidance and counseling regarding substance abuse, alcohol misuse, tobacco use, obesity, exercise and healthy diet/nutritional counseling as indicated, • Behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related disease • Screening procedure recommendations (such as breast cancer, colorectal cancer, osteoporosis) • Review of laboratory test results available at the time of the encounter • Counseling regarding minimizing exposure to ultraviolet radiation in persons 10–24 years of age • Screening and counseling for domestic and interpersonal violence • Counseling and education regarding FDA-approved contraception methods for women with reproductive capacity • Identification of persons age 65 and older at risk for falls (see page 10 for additional services related to prevention of falls) 		<p>If counseling services are required beyond what is described as included in the preventive medicine E&M visit codes, see specific counseling codes in the following section, as well as the following codes:</p> <p>96110 (developmental testing , limited (such as developmental screening test II)</p> <p>S0302 – early periodic screening, diagnosis and treatment (EPSDT)</p> <p>96040, S0265 (genetic counseling, each 30 minutes or 15 minutes respectively) such as for BRCA counseling: up to three visits for a preventive indication</p> <p>97802–04, S9470 (medical nutrition therapy services) up to three visits for a preventive indication</p> <p>G0442, G0443, G0444, G0445, G0446, G0447, G0449, G0450, G0451</p>

<p style="text-align: center;">Preventive coverage</p>	<p>ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)</p>	<p>CPT codes/ HCPCS codes (represent the services listed)</p>
<p>Preventive medicine, individual counseling</p> <p>CPT codes 99401–99404 are designated to report services provided to individuals at a face-to-face encounter for the purpose of promoting health and preventing illness or injury.</p> <p>Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as:</p> <ul style="list-style-type: none"> • Diet and exercise (such as related to obesity, hyperlipidemia) • Substance misuse/abuse • Tobacco use and cessation • Sexual practices, and STD/STI prevention • Screening procedures and laboratory test results available at the time of the encounter • Breast-feeding counseling and support (see page 10 for Breast-feeding equipment and supplies) • Domestic and interpersonal violence • FDA-approved contraception methods for women with reproductive capacity <p>Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment.</p> <p>These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness.</p> <p>For counseling individual patients with symptoms or established illness, use the appropriate office, hospital, consultation or other evaluation and management codes.</p>	<p>V65.3, V65.42, V65.44, V65.45</p>	<p>99401–99404</p> <p>If behavior change interventions are required beyond what is described in the preventive medicine counseling code descriptions here, see specific codes in the following section which represent smoking and tobacco cessation counseling, alcohol or substance abuse screening and counseling</p> <p>G0443, G0445, G0446, G0447 S9443</p>
<p>Behavior change interventions</p> <p>CPT codes 99406–99412 are designated to report services provided to individuals at a face-to-face encounter and are utilized for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse or obesity. Behavior change services may be reported when performed as part of the treatment of conditions related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.</p>	<p>V65.42, V79.1</p>	<p>99406–99412</p> <p>G0446, G0447</p>

<p style="text-align: center;">Preventive coverage</p>	<p>ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)</p>	<p>CPT codes/ HCPCS codes (represent the services listed)</p>
<p>Routine immunizations and administration of vaccines</p> <p>Please note that immunizations that are administered solely for the purpose of travel or occupation are typically excluded from coverage in most Cigna plans.</p> <p>There are four immunization schedules on the website of the Centers for Disease Control (CDC). These represent the routine immunization services that are currently designated as preventive care by the PPACA regulations. The schedules are:</p> <ul style="list-style-type: none"> • Childhood: ages zero through six years • Childhood : ages seven through 18 years • Childhood: catch-up schedule • Adult schedule <p>Refer to the CDC website to view the schedules: cdc.gov/vaccines/schedules/index.html.</p> <p>Diphtheria, tetanus toxoids and acellular pertussis (DTaP) (Tdap) (Td)</p> <p>Haemophilus influenzae type b conjugate (Hib)</p> <p>Hepatitis A (HepA)</p> <p>Hepatitis B (HepB)</p> <p>Human papillomavirus (HPV) (age and gender criteria apply)</p> <p>Influenza vaccine</p> <p>Measles, mumps and rubella (MMR)</p> <p>Meningococcal (MCV)</p> <p>Pneumococcal (pneumonia)</p> <p>Poliovirus (IPV)</p> <p>Rotavirus</p> <p>Varicella (chickenpox)</p> <p>Zoster</p>	<p>V20.2, V70.0, V03.5, V03.6, V03.7, V03.81, V03.82, V03.89, V04.0, V04.2, V04.3, V04.6, V04.8, V04.81, V04.89, V05.3, V05.4, V06.1, V06.2, V06.3, V06.4, V06.5, V06.6, V06.8, V06.9</p>	<p>Administration codes:</p> <p>90465–90468 (to be replaced 1/1/2011 with CPT codes 90460, 90461)</p> <p>90471–90474, G0008, G0009, G0010, J3530</p> <p>Vaccine codes:</p> <p>90696, 90698, 90700, 90702, 90703, 90714, 90715, 90719, 90720, 90721, 90723, 90647, 90648</p> <p>90632–90634, 90636, 90740, 90743, 90744, 90746, 90747, 90748</p> <p>90649, 90650</p> <p>90654–90658, 90660–90664, 90704, 90705, 90706, 90707, 90708, 90710</p> <p>90732, 90733, 90734, 90644</p> <p>90669, 90670, 90672, 90732, S0195 90712, 90713, 90680, 90681</p> <p>90716, 90736</p> <p>Q2034, Q2035, Q2036, Q2037, Q2038, Q2039 (Medicare only)</p>
<p>Screenings</p> <p>Additional laboratory or procedural services if ordered, will be subject to standard medical plan provisions of deductible, coinsurance or copay by the patient. Venipuncture associated with preventive laboratory screenings will be paid as a preventive service.</p>		<p>36415, 36416</p>
<p>Abdominal aortic aneurysm screening by ultrasonography: men, age 65–75 who have ever smoked</p>	<p>V70.0, V70.8</p>	<p>76700, 76705, 76770, 76775, G0389</p>

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Screenings (continued) Anemia screening, iron deficiency: pregnant women	Covered as preventive only when submitted with a maternity diagnosis code	85013, 85014, 85018, 85025, 85027, 85041, G0306, G0307
Bacteriuria screening with urine culture: pregnant women at 12–16 weeks gestation or at the first prenatal visit, if later	Covered as preventive only when submitted with a maternity diagnosis code	87086, 87088
Breast cancer screening: women age 40 and older: screening mammography with or without clinical breast exam, every one to two years	V76.10, V76.11, V76.12, V76.19, V10.3, V16.3	77055, 77056, 77057, 77051, 77052, G0202, G0204, G0206
Cervical cancer screening: <ul style="list-style-type: none"> • Pap smear, women age 21–65 every three years • HPV DNA test in combination with Pap smear, women age 30–65, every five years 	V76.2, V72.32	87620–22, 88141–43, 88147–48, 88150, 88152, 88153, 88154, 88164–67, 88174–75, G0101, G0123–24, G0141, G0143–45, G0147–48, P3000, P3001, Q0091
Chlamydial infection screening: all sexually active women age 24 and younger, and older women at increased risk	V73.88, V73.98: or a maternity diagnosis code	86631–32, 87110, 87270, 87320, 87490–92, 87810, G0450
Cholesterol screening (dyslipidemia): children at risk due to known family history, when family history is unknown, or with personal risk factors such as obesity, high blood pressure or diabetes, after age two but by age 10 (periodicity schedule/Bright Futures)	V 77.91	80061, 82465, 83718, 83719, 83721, 84478
Cholesterol screening (dyslipidemia) in adults: <ul style="list-style-type: none"> • Men age 35 and older: or age 20–35 if risk factors for coronary heart disease are present • Women age 45 and older: or age 20–45 if risk factors for coronary heart disease are present 	V77.91	80061, 82465, 83718, 83719, 83721, 84478
Colorectal cancer screening: beginning at age 50 by any of the following methods: <ul style="list-style-type: none"> • Fecal occult blood testing (FOBT)/fecal immunochemical test (FIT), annually; or • Sigmoidoscopy every five years; or • Colonoscopy every 10 years; or • Computed tomographic colonography¹ (virtual colonoscopy) every five years; or • Double contrast barium enema (DCBE) every five years 	V76.41, V76.50, V76.51, V76.52, V16.0, V18.51	82270, 82274, G0328, 45330, 45331, 45338, 45339, G0104, 45378, 45380, 45381, 45383, 45384, 45385, G0105, G0121 74263 ¹ 74270, 74280, G0106, G0120, G0122 00810, 88305
Congenital hypothyroidism screening: newborns	V77.0, V20.2	84436, 84437, 84443
Diabetes screening: adults with sustained blood pressure greater than 135/80 (whether treated or untreated)	V77.1	82947, 82948, 83036

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Screenings (continued) Gestational diabetes: pregnant women at first prenatal visit for those at risk; all pregnant women at 24 to 28 weeks gestation	Covered as preventive only when submitted with a maternity diagnosis code	82950, 82951, 82952
Gonorrhea screening: sexually active women including pregnant women if they are at increased risk for infection	V74.5: or a maternity diagnosis code	87850, 87590, 87591, G0450
Gonorrhea: prophylactic ocular medication for all newborns to prevent blindness (typically instilled at birth)	V20.2	No specific code; typically included on hospital billing, miscellaneous charge
Hearing screening: infants, children through age 10 (not a full hearing examination)	V20.2	May be a component of the preventive E&M visit service or 92551, 92552, 92553, 92558, 92568, 92583, 92586, 92587
Hemoglobin or hematocrit: infants, children (see anemia screening for pregnant women, page 8)	V20.2	85013, 85014, 85018, 85025, 85027, 85041, G0306, G0307
Hemoglobinopathy screening for sickle cell disease: newborns	V78.2	85660
Hepatitis B screening: pregnant women, first prenatal visit	Covered as preventive only when submitted with a maternity diagnosis code	87340, 87341, G0450
HIV screening: pregnant women, adolescents and men at risk ; annually for sexually active women	V73.89: or a maternity diagnosis code	86701, 86703, 87390, G0432, G0433, G0435, S3645
Hypothyroidism, congenital: newborns	V77.0	84436, 84437, 84443
Lead screening for children at risk for lead exposure (periodicity schedule/Bright Futures)	V20.2	83655
Newborn metabolic screening panel (specific combination of tests will vary according to state law): there are not designated codes for all heritable diseases which are identified for screening in this recommendation	V20.2, V78.3	S3620
Nutrition counseling for adults with hyperlipidemia, and other known risk factors for cardiovascular and diet-related chronic disease; nutrition counseling and behavioral interventions to promote sustained weight loss for obese adults and children age six years and older	V65.3, V77.8	97802, 97803, 97804, S9470 May also be performed as component of preventive E&M visit or in context of preventive counseling visit (99401–99404)
Osteoporosis screening: women age 65 or older (or younger women at risk) ²	V82.81, V17.81	76977, 77078, ² 77080, 77081, G0130
Ovarian cancer/breast cancer risk: referral/counseling for women whose family history is associated with increased risk for BRCA1 and BRCA2 gene mutations	V26.33, V16.3, V16.41	96040, S0265
BRCA1/BRCA2 genetic testing for susceptibility to breast or ovarian cancer: women	Covered only when authorized by Precertification process	81211 ³ -81217 ³

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Screenings (continued) Phenylketonuria (PKU) screening: newborns	V20.2, V77.3	84030
Prevention of falls: Physical therapy for community dwelling adults age 65 and older who are at risk for falls (effective on or after 5/1/2013 depending on plan renewal date)	V15.88, V57.1, V69.0, V69.9, 728.87	97001, 97002, 97110, 97112, 97113, 97116, 97150, 97530, G0159, S8990, S9131
Prostate cancer screening: PSA age 50 and older or age 40 with risk factors	V76.44, V16.42	84152, 84153, 84154, G0103
Rh incompatibility screening: Rh (D) blood typing and antibody testing for all pregnant women at first visit and repeat for unsensitized Rh negative women at 24–28 weeks	Covered as preventive only when submitted with a maternity diagnosis code	86900, 86901
Syphilis screening: all pregnant women and persons at increased risk of syphilis infection	V74.5; or a maternity diagnosis code	86592, 86593, G0450
Tobacco use: counseling and interventions for tobacco cessation in adults who smoke	Any diagnosis code	99406, 99407; HCPCS codes C9801, C9802 will be replaced with G0436, G0437 effective 1/1/2011
Tuberculin testing: children and adolescents at high risk	V20.2, V74.1	86580
Visual impairment screening: age three through age 18 (USPSTF and periodicity schedule/Bright Futures)	V20.2	Preventive E&M visit component or 99173

¹ CPT code 74263 (computerized tomographic colonography) requires precertification

² CPT code 77078 (computed tomography, bone density study) requires precertification

³ CPT codes 81211-81217 (BRCA1/BRCA2 testing) require precertification

Breast-feeding equipment and supplies	Examples	HCPCS codes
Provision of breast pumps and supplies for postpartum women to ensure successful breast-feeding. Requires a prescription and must be ordered through CareCentrix, Cigna's national durable medical equipment vendor ⁴ .	Breast pump, manual (purchase only)	E0602
	Breast pump, electric (rental)	E0603
	Breast pump, hospital grade	E0604 ⁵
	Supplies	A4281–A4286

⁴ This benefit is one of the recommendations issued by the Department of Health and Human Services (HHS) for preventive care services for women. It becomes effective for applicable health plans upon inception or renewal date on or after August 1, 2012. Plans exercising their rights under the grandfather provision or for an exemption do not cover these services except for medical necessity. Consult Cigna resources for your patient's plan coverage.

⁵ HCPCS code E0604 requires precertification

Contraceptive services for women

The following contraceptive methods are covered for women with reproductive capacity.^{6,7}

Method/type	Examples	CPT/HCPCS codes
Services for insertion/removal of intrauterine devices, implants; fitting diaphragm or cervical cap		58300–58301, 11976, 11981–11983, 57170, S4981
IUD devices	Mirena, ParaGard, Skyla	J7302, J7300, J3490 ⁸ (J3490 must be submitted with V25.11 or V25.13)
Injection	Depot medroxyprogesterone acetate	J1050 (Use J1050 when physician administration is required; must be submitted with V25.49); 96372 (must be submitted with V25.49)
Implants	Implanon, Nexplanon	J7307
Surgical sterilization procedures for women		58565, 58600, 58605, 58611, 58615, 58670, 58671, 00851, A4264

- ⁶ This benefit is one of the recommendations issued by the Department of Health and Human Services (HHS) for preventive care services for women. It becomes effective for applicable health plans upon inception or renewal date on or after August 1, 2012. Plans exercising their rights under the grandfather provision or for an exemption do not cover these services under preventive care, but may cover under normal medical benefits. Consult Cigna resources for your patient's plan coverage.
- ⁷ Please refer to Cigna's "No Cost Preventive Medications by Drug Category" Guide for information on drugs and products with no out-of-pocket cost to individuals, including Food and Drug Administration (FDA) approved female contraceptives; available at URL: cigna.com/pdf/839232_HCR_Preventive_Care_V02.pdf. Customers should refer to their specific plan materials or visit myCigna.com or myCignaforHealth.com for details.
- ⁸ HCPCS code J3490 requires precertification.



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