**Claim accuracy edit for stone removal during cystourethroscopy effective April 1**

Claims for services billed with both Current Procedural Terminology (CPT®) codes 52352 and 52346 for stone removal during a cystourethroscopy amended with modifiers 59 or XU will be reviewed for coding accuracy. Modifier 59 is used to bill for a distinct procedural service that is independent from other services performed on the same day. Modifier XU is used to bill for an unusual non-overlapping service performed on the same day.

We will implement a claim edit to review operative reports and deny the CPT code appended with modifier 59 as being coded inaccurately if only one stone was removed. This update is effective for dates of service on or after April 1.

Information about the update will be included in the Q2 2021 issue of Network News.

**Reimbursement policy update – Medically unlikely edit limits and modifier overrides for laboratory services effective May 16**

We routinely review our coverage, reimbursement, and administrative policies for potential updates. In that review, we take into consideration one or more of the following: Evidence-based medicine, professional society recommendations, Centers for Medicare & Medicaid Services guidance, industry standards, and our other existing policies.

As a result of a recent review, we will reimburse laboratory services billed with Current Procedural Terminology (CPT®) codes 83921, 86318, 86332, 86353, and 87798 up to the medically unlikely edit (MUE) limits assigned by the Centers for Medicare & Medicaid Services (CMS). Any units exceeding the MUE limit will be denied. Modifiers will not be allowed to override MUE limits for these codes.

We will update the Frequency Editing (R34) reimbursement policy to reflect this change. This update is effective for claims processed on or after May 16, 2021.

For more information about our reimbursement policies, visit the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Reimbursement and Payment Policies.

**Reimbursement policy update – Modifier 59 – Distinct Procedural Service effective May 16**

We routinely review our coverage, reimbursement, and administrative policies for potential updates. In that review, we take into consideration

one or more of the following: Evidence-based medicine (EBM), professional society recommendations, Centers for Medicare & Medicaid Services (CMS) guidance, industry standards, and our other existing policies.

As a result of a recent review, we will deny reimbursement for debridement services with modifier 59 when billed with a code for an arthroscopic procedure by the same provider, on the same date of service, for the same patient. Arthroscopic debridement is considered incidental to the arthroscopic procedure and is not separately reimbursable.

We will update the Modifier 59 – Distinct Procedural Service (M59) reimbursement policy to reflect this change.

Detailed information on affected codes is available in the policy. This update is effective for claims processed on or after May 16, 2021.

**Additional information**

For more information about our coverage policies, visit the Cigna for Health Care Professionals website (CignaforHCP.com) > Review coverage policies.