# CLINICAL CLAIM REVIEW NOT-PAYABLE REASON CODES

**For Providers**

**Updated April 15, 2017**

Cigna routinely conducts prepayment and post-payment claim reviews to ensure billing and coding accuracy. If we determine that a claim – or a portion of a claim – is not payable, we will provide the appropriate reason code in an explanatory letter we send to you. The chart below contains Cigna's not-payable reason codes, along with their descriptions, specific supporting policy and coverage positions, and clarifying examples.

| Reason Code | Description with Cigna Reimbursement Policy and Coverage Position | Examples include, but are not limited to: |
|---|---|---|
| 100 | **Routine service or supply, not separately billable – inclusive in procedure or room and board**<br>*Cigna Reimbursement Policy R12* | • Admission kit<br>• Sutures, staples, clips, and sealants (internal and external)<br>• Bovie, including related supplies<br>• IV start kit and supplies<br>• Trays for line insertions during procedures (e.g., central lines, PICC line tray, arteriogram drapes)<br>• Blood pressure cuff<br>• Stethoscope |
| 101 | **Routine service or supply, not separately billable – inclusive in procedure** *(See code 100)* | RETIRED 10-15-10 (DO NOT USE) |
| 102 | **Routine service or supply, not separately billable – inclusive in operating room charges** *(See code 100)* | RETIRED 10-15-10 (DO NOT USE) |
| 103 | **Routine service or supply, not separately billable – inclusive in room and board** *(See code 100)* | RETIRED 10-15-10 (DO NOT USE) |
| 104 | **Routine service or supply, not separately billable – inclusive in dialysis charge**<br>*Cigna Reimbursement Policy R16* | Select lab tests, drugs, and supplies associated with dialysis treatment (e.g., tubing, filters, or dialysate) |
| 105 | **Nursing function or standard of care and/or services performed on respiratory care routine rounds are not separately billable**<br>*Cigna Reimbursement Policies R12 and R15* | • Tracheostomy care<br>• Central line care<br>• Inpatient infusion services<br>• Medication administration |
| 105A | **Chemotherapy nursing function or standard of care – not separately payable**<br>*Cigna Reimbursement Policies R12 and R14* | Inpatient chemotherapy infusion services |

| Reason Code | Description with Cigna Reimbursement Policy and Coverage Position | Examples include but are not limited to: |
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| 106 | **Point of care (POC) services are a nursing function or standard of care – not separately payable**<br>*Cigna Reimbursement Policies R12 and R15* | REINSTATED 07/24/17<br>(USE STARTING 07/24/17) |
| 107 | **Inconsistent with standard for this medication – clinically inappropriate dosage**<br>*Cigna Reimbursement Policy R14* | Vancomycin 250 mg x 16 equals 4000 mg per day, which exceeds the standard daily dosage for this drug |
| 108 | **Duplicate charge** | Self-evident |
| 109 | **Outpatient transfusion** service codes (Rev 391) are payable once per day regardless of the number of units or different types of blood products transfused. **Administration fees are not additionally reimbursed on inpatient claims,** and are considered a nursing standard of care.<br>*Cigna Reimbursement Policies R12, R14, and R16* | Blood product administration (e.g., fresh frozen plasma [FFP], cryoprecipitate [CRYO], packed red blood cells [RBCs]) |
| 110 | **Professional fees require additional detail** | RETIRED 03/01/10<br>(DO NOT USE) |
| 111 | **Capital equipment, durable medical equipment (DME) – excluded service.** Charges for the use of capital equipment, when billed, in addition to service charges or procedures associated with that equipment, are not separately payable. DME items not required for immediate discharge must be supplied by a Cigna contracted, licensed DME vendor.<br>*Cigna Reimbursement Policy R12* | DME items other than wheelchairs, walkers, crutches, ambulatory assist aids, etc.<br>**Capital equipment** –<br>• Hospital beds<br>• Cell saver<br>• IV pumps<br>• Feeding pumps<br>• Wound vacuum assisted closure (VAC) systems<br>Equipment, whether purchased, rented or leased, is considered inclusive in the daily room and board charges, and therefore not separately reimbursable.<br>**MERGED WITH FORMER CODE 148** |
| 112 | **Out-of-date range for this claim. Excludes preadmission testing within 72 hours of admission or scheduled outpatient surgical procedure.** | |
| 113 | **Not separately billable – included in pharmacy charges**<br>*Cigna Reimbursement Policy R14* | • Diluent / admixtures<br>• Mixing charges<br>• Compounding fees<br>• Pharmacist fees |
| 114 | **Not separately reimbursable – oxygen included in vent, bi-level positive airway pressure (BiPAP), or continuous positive airway pressure (CPAP) charge.** Cigna reimburses the most comprehensive service per day.<br>*Cigna Reimbursement Policy R15* | Oxygen, air, compressed air, med-gas charges on the same day as the vent, BiPAP, or CPAP charges |
| 115 | **Healthcare Common Procedure Coding System (HCPCS) all inclusive – components are not separately payable per National Correct Coding Initiative (NCCI) Guidelines**<br>*Cigna Reimbursement Policy R09* | Cochlear implant leads that come with the implant kit, neurostimulator antennae and stimulator, etc. |

  

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|---|---|---|
| 116 | **Critical care unit standard of care – not separately payable**<br>*Cigna Reimbursement Policy R12* | • Pulse oximetry<br>• Electrocardiogram (EKG)<br>• Carbon dioxide<br>• Any line monitoring<br>• Intracranial pressure |
| 117 | **Internal transport fees – non-payable**<br>*Cigna Reimbursement Policy R12* | Patients being transported from one area of the hospital campus to another |
| 118 | **External transport fees:** Ambulance transfers must be billed on a CMS-1500 form by the company that provided the transport. Facility-owned ambulance services may be billed on a UB-04 or CMS-1450 form.<br>*Cigna Reimbursement Policy R18* | |
| 119 | **Set-up fees, inclusive in procedure performed – not separately payable**<br>*Cigna Reimbursement Policies R12, R15 and R16* | • Oxygen set up<br>• Ventilator set up<br>• Operating room set up |
| 120 | **Portable fees, inclusive in procedure performed – not separately payable**<br>*Cigna Reimbursement Policy R12* | Portable fees charged in addition to the diagnostic procedure (e.g. portable X-ray fees in addition to X-ray, or those demonstrating higher cost for STAT chest X-ray versus a chest X-ray) |
| 121 | **Service not billable on an inpatient claim in accordance with NCCI and Uniform Billing guidelines**<br>*Cigna Reimbursement Policy R09* | Clinic services Rev 510 or ambulatory surgery services Rev 490 billed on same UB as inpatient hospitalization or operating room Rev 360 |
| 121A | **Stat fees, inclusive in procedure performed – not separately payable**<br>*Cigna Reimbursement Policies R12 and R17* | Stat fees charged in addition to any service or procedure: Hematocrit / hemoglobin (H/H) stat fee x two |
| 121B | **Rental fees are included in the daily room and board fees, and are not separately payable**<br>*Cigna Reimbursement Policy R12* | Rental beds |
| 121C | **Specimen handling or delivery fees – not separately payable**<br>*Cigna Reimbursement Policies R12 and R17* | Usually associated with laboratory tests |
| 121D | **Standby fees – not additionally reimbursable**<br>*Cigna Reimbursement Policies R12 and R15* | Operating room standby for cardiac catheterization or respiratory, labor and delivery, or neonatal intensive care unit standby when code is called |
| 122 | **Services unbundled or mutually exclusive or incidental to another procedure in accordance with NCCI guidelines**<br>*Cigna Reimbursement Policy R09* | Procedural unbundling (lesser procedures not additionally payable with a greater procedure) (e.g., diagnostic bronchoscopy billed with bronchoscopy with biopsy or appendectomy incidental to a hysterectomy, etc.) |

  

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| 123 | **Operating room / anesthesia / recovery room time inconsistent with procedure performed** – requires additional documentation or facility to rebill correctly<br>*Cigna Reimbursement Policy R12* | Operating room minutes should never exceed anesthesia minutes billed |
| 124A | **Not a payable benefit or other non-covered service**<br>*Per participant's benefit plan or Cigna coverage policies* | |
| 124B | **Experimental / investigational / unproven (E/I/U) service or supply** | Use of nitric oxide, off-label use of factor products, etc., not a payable benefit under participant's benefit plan as determined E/I/U by physician review |
| 124C | **Service denied for medical necessity** | Intraoperative monitoring (IOM) of somatosensory evoked potentials (SSEP) during orthopedic surgery determined not medically necessary by physician review |
| 125 | **Condition does not support need for a private room**<br>*Cigna Reimbursement Policy R12* | Any condition that does not require patient isolation |
| 126 | **Room charges exceed authorized level of care (LOC) – send to medical director or LOC coordinator for clarification or confirmation**<br>*Cigna Reimbursement Policy R12* | Requires referral to a medical director |
| 127 | **Nursing increments included in room and board, service, or procedure – no additional payment.** Extraordinary circumstances will require additional documentation supporting the need for additional nursing care and will be referred to a medical director.<br>*Cigna Reimbursement Policy R12* | Nursing care charges in addition to room and board charges or Rev 23X |
| 128A | **Medications ordered but not given are not payable**<br>*Cigna Reimbursement Policy R14* | Not documented is considered not administered |
| 128B | **Medications given but not ordered are not payable**<br>*Cigna Reimbursement Policy R14* | Self-evident |
| 128C | **Medications ordered but not given due to patient non-compliance or other reason are not payable**<br>*Cigna Reimbursement Policy R14* | The patient was unable to take anything by mouth due to imaging procedure or patient refused |
| 129A | **Tests or services ordered but not provided are not payable** | Not documented is considered not administered |
| 129B | **Tests or services provided but not ordered are not payable** | Self-evident |
| 129C | **Tests or services ordered but not provided due to patient non-compliance or other reason are not payable** | Self-evident |
| 130 | **Equipment monitoring services charged when equipment not in use** | Self-evident |
| 131 | **Vent, BiPAP, CPAP or oxygen charges exceed 24 hours per day (self-evident error)**<br>*Cigna Reimbursement Policy R15* | Defined as a daily charge |

  

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|---|---|---|
| 132 | **Item unidentifiable, unlisted, or unspecific, or in question.** All providers must identify and certify the medical necessity of the drug, service, supply, or procedure for which they are requesting reimbursement.<br>*Cigna Reimbursement Policies R08, R12, and R13* | Miscellaneous charges for drugs, services, procedures, supplies, implants, etc. |
| 133 | **Personal item charged** – not a payable benefit per participant benefit plan or Cigna coverage policies<br>*Cigna Reimbursement Policy R12* | Comfort or convenience item |
| 134 | **Incorrect room charge – inappropriate per bed request, LOC, or not used on bill date** | RETIRED 10/15/10 (DO NOT USE) |
| 135 | **Observation charges billed in conjunction with ambulatory surgery center or hospital outpatient services are considered integral to the base procedure and not separately payable unless otherwise specified**<br>*Cigna Reimbursement Policy R12* | Observation billed in addition to an outpatient procedure when routine monitoring and recovery is included |
| 136 | **Service inappropriate for age, gender, etc. – Medically Unlikely Edits (MUE)** per NCCI guidelines<br>*Cigna Reimbursement Policy R09* | Hysterectomy charges for a male |
| 137 | **Data entry error** | Self-evident |
| 138 | **Present on admission (POA) indicators missing**. Cigna reserves the right to reject any claims from facilities, other than those noted as exceptions, which refuse to supply POA indicators with their inpatient billing. In addition, this fails to meet UB04 Clean Claim requirements.<br>*Cigna Reimbursement Policy R05* | Does not apply to long-term acute care (LTACH), critical access hospitals, LTACH hospitals, Maryland waiver hospitals, cancer hospitals, children's inpatient facilities, rural health clinics, federally qualified health centers, and religious non-medical health institutions |
| 138A | **Possible Never Event**<br>*Cigna Reimbursement Policy R05* | Requires referral to a medical director |
| 138B | **Possible Hospital Acquired Condition**<br>*Cigna Reimbursement Policy R05* | Requires referral to a medical director |
| 139 | **Item not payable on an inpatient claim**<br>*Per Cigna Administration Guidelines* | RETIRED 04/01/10 (DO NOT USE) |
| 140 | **Charge reduced based on average wholesale price (AWP) or wholesale acquisition cost (WAC)**<br>*Per contractual agreement* | |
| 141 | **Implant charge reduced based on invoice pricing for this item per contractual agreement**<br>*Cigna Reimbursement Policy R13* | |
| 142 | **Total parenteral nutrition (TPN) administration charges do not adhere to Cigna Coverage Policy 0136 and Reimbursement Policy R14** | Continuous TPN billable only one time per day or if billed hourly, not to exceed 24 units per day |
| 143A | **Operating room or anesthesia standard of care – not separately payable**<br>*Cigna Reimbursement Policy R12* | Positioning devices |

  

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|---|---|---|
| 143B | **Anesthesia monitoring standard of care** – **not separately reimbursable.** Includes any measure routinely monitored by anesthesia for the required level of consciousness per the American Society of Anesthesiologists (ASA) *Guidelines for Patient Care in Anesthesiology* (Approved by the ASA House of Delegates on October 3, 1967, and last amended on October 18, 2006)<br>*Cigna Reimbursement Policy R12* | • Pulse oximetry<br>• Bispectral index (BIS) monitoring<br>• Arterial blood gas (ABG)<br>• Electrolytes |
| 144 | **Operating room and anesthesia charges unbundled – included in procedure** | RETIRED 04/01/10<br>(DO NOT USE) |
| 145 | **Perfusion services include all charges for the perfusionist and all supplies related to cardiopulmonary bypass**<br>*Cigna Reimbursement Policy R12* | Clarification: Perfusion itself is a payable service. However, perfusion supplies are covered only if there are no other charges billed for the perfusion services or a perfusionist. |
| 146 | **Contrast or dye not separately billable** – **inclusive in procedure per descriptor in HCPCS or Current Procedural Terminology (CPT).** Per HCPCS, the contrast is all-inclusive when billing for these studies; reportable but not additionally reimbursable.<br>*Cigna Reimbursement Policies R09 and R12* | When the CPT code or descriptor contains the words “with contrast” or “with and without,” the contrast material will not be additionally reimbursed. |
| 147 | **Charge not separately billable for echocardiogram (echo).** Echo has three allowable component charges: (1) two-dimensional (2D) echo, M-mode, and doppler; (2) Echo mode and 2D W/O; and,(3) doppler color plow per CPT section descriptor, echocardiography<br>*Cigna Reimbursement Policies R09 and R12* | Basic adherence to standard coding principles. Facility may rebill correctly for reconsideration under Cigna's appeals process. |
| 148 | **Charges for the use of capital equipment when billed in addition to service charges or procedures associated with that equipment, are not separately payable**<br>*Cigna Reimbursement Policy R12* | RETIRED 05/15/11<br>(DO NOT USE)<br>**MERGED WITH REASON CODE 111** |
| 149 | **Unbundled charge included lab panel, either POC or by draw – please rebill as a panel**<br>*Cigna Reimbursement Policy R17* | ABG draw with unbundled electrolytes. |
| 150 | **Excessive items or supplies.**<br>*Cigna Reimbursement Policy R09* | Three incentive spirometers billed during a routine inpatient admission. |
| 151 | **Multiple surgery reduction – outpatient (OP)** | |
| 152 | **Multiple endoscopy rules apply – OP** | |
| 153 | **Perioperative blood salvage (cell saver) is included in the procedure fee – not separately payable**<br>*Cigna Reimbursement Policy R12* | |
| 154 | **Cigna is not financially responsible for any service or supply that must be duplicated due to facility or provider error or waste** | |
| 155 | **Blood draws off an existing port or line are not reimbursable**<br>*Cigna Reimbursement Policies R12 and R17* | |

  

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|---|---|---|
| 156 | **Not billed appropriately under correct revenue code or CPT/HCPCS. Does not meet standard description of code or UB Editor guidelines**<br>*Cigna Reimbursement Policies R09 and R25* | |
| 157 | **Operative report or medical records do not support procedures, supplies, or implants billed**<br>*Cigna Reimbursement Policies R09, R12, and R13* | |
| 158 | **Mom's charges found on baby claim – please rebill correctly** | Self-evident |
| 159 | **Supplies and equipment used in conjunction with robotic surgery are not additionally reimbursable**<br>*Cigna Reimbursement Policy R04; also see R12* | Should be used only with robotics denials in Cigna Reimbursement Policy R04. |
| 160 | **Recalled device or implant** | • The device or implant was recalled by the U.S. Food & Drug Administration (FDA) and / or the manufacturer<br>• It is replacing a previously recalled unit<br>• Additional information is required to reimburse correctly |
| 161 | **These services denied on prior authorization.** Please see adverse benefit determination associated with that denial. | A denial for services was issued prior to services being rendered. |
| 162 | **This service is reduced or denied for no authorization on file.** Services rendered required prior authorization. | RETIRED 11-1-16<br>(DO NOT USE) |
| 163 | **Operative report does not support the separate billing of cervical corpectomy (CPT codes 63081 and 63082) with cervical fusion**<br>*Cigna Reimbursement Policy R-24* | Cigna aligns with the use of CPT codes for billing (as supported by the American Medical Association's monthly periodical, *CPT Assistant*) and the North American Spine Society (NASS) billing guidance for cervical vertebral corpectomy. For the procedure to be billed as a corpectomy, half the vertebral body must be resected. Typically, the resected area includes the disc space above and below it. Therefore, separate reimbursement is only provided when the operative notes identify that at least 50 percent of the vertebral body was resected. |
| 999 | **OTHER** | Not elsewhere classifiable (NEC) |