Reimbursement Policy

Effective Date 06/14/2018
Reimbursement Policy Number R24

Omnibus Reimbursement Policy

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INSTRUCTIONS FOR USE
*Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy Proprietary information of Cigna. Copyright ©2020 Cigna*

Overview

Some reimbursement or modifier policy statements require only a couple of sentences to describe; an in-depth individual policy is not required. This document contains a collection of reimbursement or modifier statements that do not require their own policy.

For reimbursement policies that do have individual documents, please log in to the Cigna for Health Care Professionals website at (CignaforHCP.com > Useful Links > Policies and Procedures > Modifiers and Reimbursement Policies> select either Modifier or Reimbursement).

Reimbursement Policy

Reimbursement Policy	Policy Detail	Applicable Claim Form
After-Hours Care	Cigna is aligned with Centers for Medicare and Medicaid Services (CMS) for after-hours services represented by CPT® codes 99051–99056 and 99060 which are assigned a status of "B". CMS assigns a status of "B" (Bundled Code) to the denied procedure, which is defined, "Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amount for these codes and no separate payment is made. When these services are covered, payment for them is	CMS 1500

Reimbursement Policy	Policy Detail	Applicable Claim Form
	subsumed by the payment for the services to which they are incident. A Modifier will not over-ride the edit". However, Cigna supports physicians' efforts to treat patients in the office setting (Place of Service 11) rather than refer them to emergent or urgent care when the service either disrupts regularly scheduled office hours or occurs outside of regularly scheduled office hours. Accordingly, separate reimbursement is allowed for after-hours CPT® code 99050 when billed with one of the Evaluation and Management (E/M) codes from the following list and the E/M code is eligible for payment: 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 and the E/M code is eligible for payment: 99201-99205 and 99212-99215. Please note: Separate reimbursement for after-hours codes 99050 and 99058 is allowed on claims where only those codes and the appropriate E/M code (see list above) are billed. Adding additional codes to the claim may alter the payment for the after-hours code.	
Cervical Corpectomy (63081, 63082) with Cervical Fusion	Cigna aligns with CPT®/CPT® Assistant and the North American Spine Society (NASS) billing guidance for cervical vertebral corpectomy: "in order for the procedure to be billed as a corpectomy, half of the vertebral body must be resected. Typically, the resected area includes the disc space above and below". Therefore, separate reimbursement is only provided when the operative notes identify that at least 50% of the vertebral body was resected. This documentation should be made available to Cigna upon request.	CMS1500 and UB04
Chemotherapy	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 more details, please see the Reimbursement Policy on the secure Cigna for Health Care Professionals website at (CignaforHCP.com > Useful Links > Policies and Procedures > Modifiers and Reimbursement Policies > Modifier Policies > Modifier 25 Documentation Requirement List).	CMS 1500
Clinic Revenue Codes (510-515, 517-525, 527-529)	Cigna does not reimburse clinic facility fees for Evaluation and Management (E&M) services billed with Revenue Codes 510-515, 517-525 or 527-529.	UB04
Colonoscopy	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	CMS 1500 and UB04

Reimbursement Policy	Policy Detail	Applicable Claim Form
	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.	
Computer-Assisted Stereotactic Navigation for Cranial and Spinal Procedures	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 PTP edits.	CMS 1500
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures	Separate reimbursement is not provided for Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (CPT® codes 20985, 0054T, 0055T and 0396T) as it is considered incidental to the primary overall service.	CMS 1500
Developmental Screening (96110)	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).	CMS 1500
Drug Kits	Drug kits which contain both drugs and supplies will not be reimbursed. All drug(s) should be billed using the appropriate coding for the individual drug as supplies are not eligible for separate reimbursement.	CMS 1500
Electrical Stimulation Electrodes	The supply of electrodes is considered incidental to electrical stimulation therapy. Separate reimbursement for incidental supplies is not allowed.	CMS 1500
Electrode Replacement (A4556)	Replacement of electrodes (A4556) for use with covered durable medical equipment is limited to 48 pairs/units per year.	CMS 1500

<table>
<tr><th>Reimbursement Policy</th><th>Policy Detail</th><th>Applicable Claim Form</th></tr>
<tr><td>Fetal Non-stress Test 59025</td><td>We reimburse for 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 gestations. See the list of eligible diagnoses below:

<table>
<tr><td>O30.001</td><td>O30.002</td><td>O30.003</td><td>O30.009</td></tr>
<tr><td>O30.011</td><td>O30.012</td><td>O30.013</td><td>O30.019</td></tr>
<tr><td>O30.021</td><td>O30.022</td><td>O30.023</td><td>O30.029</td></tr>
<tr><td>O30.031</td><td>O30.032</td><td>O30.033</td><td>O30.039</td></tr>
<tr><td>O30.041</td><td>O30.042</td><td>O30.043</td><td>O30.049</td></tr>
<tr><td>O30.091</td><td>O30.092</td><td>O30.093</td><td>O30.099</td></tr>
<tr><td>O30.101</td><td>O30.102</td><td>O30.103</td><td>O30.109</td></tr>
<tr><td>O30.111</td><td>O30.112</td><td>O30.113</td><td>O30.119</td></tr>
<tr><td>O30.121</td><td>O30.122</td><td>O30.123</td><td>O30.129</td></tr>
<tr><td>O30.131</td><td>O30.132</td><td>O30.133</td><td>O30.139</td></tr>
<tr><td>O30.191</td><td>O30.192</td><td>O30.193</td><td>O30.199</td></tr>
<tr><td>O30.201</td><td>O30.202</td><td>O30.203</td><td>O30.209</td></tr>
<tr><td>O30.211</td><td>O30.212</td><td>O30.213</td><td>O30.219</td></tr>
<tr><td>O30.221</td><td>O30.222</td><td>O30.223</td><td>O30.229</td></tr>
<tr><td>O30.231</td><td>O30.232</td><td>O30.233</td><td>O30.239</td></tr>
<tr><td>O30.291</td><td>O30.292</td><td>O30.293</td><td>O30.299</td></tr>
<tr><td>O30.801</td><td>O30.802</td><td>O30.803</td><td>O30.809</td></tr>
<tr><td>O30.811</td><td>O30.812</td><td>O30.813</td><td>O30.819</td></tr>
<tr><td>O30.821</td><td>O30.822</td><td>O30.823</td><td>O30.829</td></tr>
<tr><td>O30.831</td><td>O30.832</td><td>O30.833</td><td>O30.839</td></tr>
<tr><td>O30.891</td><td>O30.892</td><td>O30.893</td><td>O30.899</td></tr>
<tr><td>O30.90X</td><td>O30.91X</td><td>O30.92X</td><td>O30.93X</td></tr>
</table></td><td>CMS 1500</td></tr>
<tr><td>Hearing Screening Codes 92558 and 92586 - Facility Place of Service</td><td>Hearing screening CPT® codes 92558 and 92586, when performed in a facility place of service, are included in the facility's reimbursement. CPT® codes 92558 (evoked otoacoustic emissions, screening [qualitative measurement of distortion product or transient evoked otoacoustic emissions] and automated analysis) and 92586 (auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited) will be denied when reported by a health care professional in a facility place of service. For more details, see Reimbursement Policy R12 Facility Routine Services, Supplies and Equipment on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Useful Links > Policies and Procedures > Modifiers and Reimbursement Policies >Reimbursement Policies).</td><td>CMS1500</td></tr>
<tr><td>Immunization Administration Codes 90460 and 90461</td><td>A frequency edit applies to charges submitted for CPT® code 90460 exceeding nine units and 90461 exceeding seven units per date of service.</td><td>CMS 1500</td></tr>
<tr><td>Intraoperative Neurophysiology Monitoring

Codes 95940, 95941, and G0453</td><td>We follow CPT® direction for coding edits associated with Intraoperative monitoring services. CPT® guidance is as follows: "When the service is performed by the surgeon or anesthesiologist, The professional services are included in the surgeon's anesthesiologist's primary service code(s) for the procedure and are reported separately." Codes 95940, 95941, and G0453 will be denied as incidental when billed in addition to a code from either the code range of 00100–01999 or the range of 10021–69990.</td><td>CMS 1500</td></tr>
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Knee Arthroscopy Procedures	We apply NCCI PTP coding edits 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 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. G0289 is denied as incidental to codes 29880 and 29881. Modifier 59 will override the edit. Documentation supporting the use of Modifier 59 must be provided to us upon request.	CMS 1500
Posterior Lumbar Interbody Fusion billed with Posterior Laminotomy or Laminectomy	A lumbar laminectomy is typically incidental to a posterior or posterolateral lumbar interbody fusion (PLIF/TLIF) except when additional decompression is required beyond that which was necessary to complete the posterior interbody fusion (CPT codes 22630-22634). Therefore, lumbar laminectomy (63030, 63035, 63042, 63044, 63047, 63048, 63056, 63057, 63005, 63012 and 63017) is/are not considered separately reimbursable unless documentation is submitted to support medical necessity for a separately identifiable decompression. Modifiers will not over-ride this incidental denial	CMS 1500
Operating Microscope (69990)	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, 64861-64871, 64885-64891, and 64905-64907. An edit will disallow the operating microscope if CPT® code 69990 is reported with other codes. Modifiers will not override these edits. **Please note:** CPT® guidelines for reporting CPT® code 69990 differ from CMS guidelines.	CMS 1500
Perfusion Assessment	Assessment of perfusion by any technology including but not limited to intraoperative fluorescent angiography, indocyanine green (ICG) fluorescence angiography or SPY ® Fluorescent Imaging System is integral to the primary procedure and is not separately reimbursed.	CMS 1500 and UB04
Prostate Needle Biopsy Surgical Pathology Exam (G0416)	Cigna is aligned with CMS in requiring the use of HCPCS code G0416 for the billing of a prostate needle biopsy surgical pathology exam. Cigna will not reimburse CPT code 88305 for this service.	CMS 1500 and UB04
Pulse Oximetry (94760-94762)	CPT® codes 94760-94762 are considered incidental to the primary service(s) provided. Separate reimbursement will not be provided when pulse oximetry is billed alone or with additional codes. A modifier will not override the denial.	CMS 1500 and UB04
Radiology	When more than one x-ray view of the same anatomical area is performed on a single date of service, only the code with the higher number of views performed will be reimbursed. (e.g., submitting a CPT code for a chest x-ray, single view and a CPT code for a chest x-ray, two views; only the code for two views will be reimbursed). Only one professional and one technical component are allowable per X-ray**.**	CMS 1500

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Respiratory Treatment	Demonstration or evaluation of patient use of an aerosol generator, nebulizer, metered dose inhaler, or IPPB device (CPT® code 94664) is considered mutually exclusive to an office visit.	CMS 1500
Scalp Cooling	Cigna aligns with CMS for scalp cooling for chemotherapy induced alopecia regardless of the code it is billed with. This service may be provided using ice-filled bags or specially designed devices and charges for such services are not separately reimbursed.	CMS 1500 and UB04
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. 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 are components 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).	CMS 1500
Specimen Handling/Conveyance (99000, 99001, 99002)	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.	CMS 1500
Supplies (99070 and A4649)	Supplies (CPT® code 99070 and HCPCS code A4649) are considered incidental to the overall primary service and are not separately reimbursable. A modifier will not override the edit.	CMS 1500 and UB04
Surgical Trays (A4550)	Separate reimbursement is allowed for surgical trays (A4550) when submitted with the following CPT® service codes: 28297, 28298, 28299; 32554; 32555; 37609; 38500; 43200; 43214; 43233; 43220; 43226; 43235; 43239; 43247; 43250; 43251; 45378; 45379; 45380; 45382; 45384; 45385; 45388; 49082; 49083; 49084; 51720; 52000; 52007; 52010; 52204-52260; 52270 - 52281; 52283; 52290 - 52310; 53020; 54057 - 54060; 54100; 54700; 55250; 57520; 58120; 62270; 96440; 96446, 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.	CMS 1500
Three Dimensional Rendering (3DR) **CPT Code 76376**	Three Dimensional Rendering (3DR) CPT Code 76376 requires little additional time or effort on the part of the health care professional. It is considered incidental to the overall radiological service and not separately reimbursable. A modifier will not override the edit.	CMS 1500
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.	CMS 1500
Urgent Care Centers-Global Fee (S9083)	HCPCS code S9083 is intended for use by Urgent Care Centers to report the global fee for an urgent care visit. Health care	CMS 1500

Reimbursement Policy	Policy Detail	Applicable Claim Form
	professionals are not eligible to be reimbursed for S9083. Reimbursement for S9083 will only be provided to Urgent Care Facilities.	
Urgent Care Services S9088	Additional reimbursement is not allowed for HCPCS code S9088 – Services provided in an urgent care center (list in addition to code for service). This code is considered incidental to the primary service(s) performed.	CMS 1500
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.	CMS 1500

References

1. Current Procedural Terminology (CPT®), © 2019 Professional Edition, American Medical Association: Chicago, IL.

2. Health Care Procedure Coding System, National Level II Medicare Codes [Los Angeles, CA: Practice Management Information Corporation (PMIC), ©2019].

3. International Classification of Diseases 10th Revision Clinical Modification (ICD10 CM), © 2019 Practice Management Information Corporation (PMIC).

Policy History/Update

Date	Change/Update
11/16/2020	Effective date, CPT codes 94760-94762 are considered incidental to the primary service(s) provided. Separate reimbursement will not be provided when pulse oximetry is billed alone or with additional codes. A modifier will not override the denial.
09/15/2020	Added policy statement for Scalp Cooling.
08/18/2020	Notification: CPT codes 94760-94762 are considered incidental to the primary service(s) provided. Separate reimbursement will not be provided when pulse oximetry is billed alone or with additional codes. A modifier will not override the denial. Effective date: 11/16/2020. Effective date for the required use of HCPCS G0416 for Prostate Needle Biopsy Surgical Pathology Exam.
05/20/2020	Notification for the required use of HCPCS G0416 for Prostate Needle Biopsy Surgical Pathology Exam, effective 08/18/2020.
02/14/2020	Added policy statement for Perfusion Assessment. Added References section.
11/11/2018	Surgical tray code list will be updated on 11/11/18 to add codes 45388, 49082, 49083, 49084 and 96446. Removed deleted codes 43234 and 96445. Corrected 43578-43580 to 45378-45380. Removed ICD9 codes for Fetal Non-Stress Testing.
09/16/18	Effective date for the denial of lumbar laminectomy when billed with a posterior lumbar interbody fusion (PLIF) with or without a modifier.
06/14/2018	Notification for the denial of lumbar laminectomy when billed with a posterior lumbar interbody fusion (PLIF) with or without a modifier effective 09/16/18.
02/15/2018	Effective date for the denial of over 48 pairs/units per year for HCPCS code A4556 and for the denial of clinic room charges billed with Revenue codes 510-515, 517-525 and 527-529 with an evaluation & management code. Also updated the code pair list for operating microscope (69990) to align with CMS (changed code range 64861-64870 to 64861-64871 and 64885-64898 to 64885-64891) and removed the codes and clarified the Radiology Policy statement.

11/17/2017	Notification for the denial of over 48 pairs/units per year for HCPCS code A4556 and for the denial of clinic room charges billed with Revenue codes 510-515, 517-525 and 527-529 with an evaluation & management code effective 02/19/2018.
07/27/2017	Denial of clinic room charges billed with Revenue Codes 510-515, 517-525 and 527-529 post-poned, therefore removed from the policy until further notice.
07/11/2017	Notification for denial of S9083 to health care professionals effective 10/21/2017 and notification for denial of clinic room charges billed with Revenue codes 510-515, 517-525 and 527-529 and an evaluation & management code also effective 10/21/2017.
10/16/2016	Effective date for documentation requirement for cervical vertebral corpectomy when billed with cervical fusion.
07/16/2016	Notification for documentation requirement for cervical vertebral corpectomy when billed with cervical fusion. Documentation to indicate at least 50% of vertebral body was removed- effective 10/16/2016.
05/16/2016	Effective date for denial of drug kits.
02/15/2016	Notification for drug kit edit. Effective 05/16/2016, drug kits will not be reimbursed. All drugs should be billed separately, supplies are not eligible for separate reimbursement. Removed electrocardiogram policy as this is now in R26 Physician Interpretation and Report Services. Removed Robotic Assisted Surgery policy as this has own separate policy: R04-Robotic Assisted Surgery.
01/01/2016	Effective date for new code 0396T which was added to Computer-Assisted Surgical Navigation for Musculoskeletal Procedures policy.
10/19/2015	Qualitative Drug Screen testing (QDST) removed from this policy and moved to R25 Drug Testing Billing Requirements Policy. Modifiers SL and SU removed from this policy as they are located in HCPCS Policy, Lab Panel policy removed as this is in the Laboratory Services Reimbursement Policy, and clarified After-Hours Care Policy language.
09/01/2015	Notification of revision of the existing Qualitative Drug Screen Testing (QDST) policy to add H0003 and H0049 as also not eligible for reimbursement. Notification that this policy will be removed from Omnibus Reimbursement Policy (R24) to be included in Drug Testing Billing Requirements (R25) as of 10/19/2015.
06/08/2015	3DR Code 76376 being incidental to the overall radiological service goes live.
03/10/2015	Notification of 3DR Code 76376 being incidental to the overall radiological service effective June 8, 2015.
02/16/2015	Revised Policy Format Effective date. See details under November 2014 Notification section below.
02/13/2015	Notification that the reimbursement policy for Qualitative Drug Screen will be updated to apply to UB 04 claims (in addition to CMS 1500 claim types) effective May 15, 2015.
11/ 2014	Notification of the creation of Omnibus Reimbursement Policy. Removed reimbursement policy statements from the Code Edit Policy and Guidelines, which are now included in the Omnibus Reimbursement Policy. Removed any policy statement for which the topic has its own independent reimbursement policy. Notification of revision of the existing Qualitative Drug Screen Testing (QDST) policy to identify that the new 2015 QDST replacement CPT® codes are also not eligible for reimbursement. Added third column that identifies what claim form type the policy statement will align.