REVENUE CYCLE MANAGEMENT

University Physicians' Association, Inc.
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Cigna Consult Codes

Cigna will be implementing a new reimbursement policy, Evaluation and Management (R30) and deny charges billed with Current Procedural Terminology (CPT) consultation codes as not valid.

This policy will be effetive for claims processed beginning October 19, 2019. In 2010, CMS discontinued reimburwsement on consultation codes and providers were required to bill using non-consultation codes. Cigna's new policy will align with CMS requirements.

Claims submitted on CMS-1500 forms are affected specific to CPT codes 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254 and 99255. This change will affect all providers who bill consultation codes.

Providers affected should have received a letter from Cigna about the new policy. Letters were mailed 7/19/19. Information about the policy update will also be included in an article in the October 2019 issue of Network News (Cigna) and posted on the Cigna for Health Care Professionals website at www.cignaforHPC.com

A copy of the Cigna Reimbursement Policy for R30 follows on pages three through six.

CLIA Requirements for Laboratory Services

Effective September 15, 2019, Amerigroup Plans will require providers who perform laboratory services to report CLIA certification numbers on claims.

Providers performing in-house labs should ensure that the appropriate CLIA certification is in effect and reported for lab services with modifier QW to indicate a CLIA waived test to receive reimbursement. Claims submitted for reimbursement without a QW modifier will not be reimbursed. Medicare,

Medicare Advantage plans, Cigna, United Healthcare, Humana already require CLIA certification and QW modifiers for CLIA waived testing reimbursement. QW modifier can be reported for all payers, for applicable tests.

Providers and office staff should be aware of their practice's CLIA waived lab tests and append QW modifier, as necessary, to appropriate lab CPTs during the charge reporting processing.

You can find full details on Amerigroup's provider notification on page 2 following.

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Provider update

Clinical Laboratory Improvement Amendments

Claims that are submitted for laboratory services subject to the *Clinical Laboratory Improvement Amendments* of *1988 (CLIA)* statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid *CLIA* certificate identification number must be reported on a *1500 Health Insurance Claim Form* (*CMS-1500*) or its electronic equivalent beginning September 15, 2019. The *CLIA* certificate identification number must be submitted in one of the following manners:

Claim format and elements	***CLIA* number location options**	**Referring provider name and NPI number location options**	**Servicing laboratory physical location**
***CMS-1500* (formerly *HCFA-1500*)**	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the address is not equal to the billing provider address. The servicing provider address must match the address associated with the *CLIA* ID entered in field 23.
HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the *CLIA* ID submitted in the 2300 loop, REF02.

Providers who have obtained a *CLIA Waiver* or *Provider Performed Microscopy Procedure* accreditation must include the QW modifier when any *CLIA* waived laboratory service is reported on a *CMS-1500* claim form in order for the procedure to be evaluated to determine eligibility for benefit coverage.

Laboratory procedures are only covered and, therefore, payable if rendered by an appropriately licensed or certified laboratory having the appropriate level of *CLIA* accreditation for the particular test performed. Thus, any claim that does not contain the *CLIA* ID, has an invalid ID, has a lab accreditation level that does not support the billed service code and/or does not have complete servicing provider demographic information will be considered incomplete and rejected or denied.

If you have additional questions, contact Provider Services at 1-800-454-3730.

07/18/2019: Notification effective 10/19/2019 New Reimbursement Policy R30 Evaluation and Management Services. The denial of use of E/M Consultation Codes.

Reimbursement Policy

Effective Date.....10/19/2019
Reimbursement Policy Number R30

Evaluation and Management Services

Table of Contents

Related Policies

Modifier 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
Modifier 25 Pair List CMS/NCCI Incidental Documentation Requirement List
Modifier MRG Modifier Reference Guide
R02 Preventive Medicine Evaluation and Management Services and Problem Based Evaluation and Management Service on the Same Day
R12 Facility Routine Services, Supplies and Equipment

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 ©2019 Cigna*

Overview

Evaluation and Management (E/M) are services provided by a physician or other qualified healthcare professional. The Current Procedural Terminology (CPT®) describes "professional services" as face to face services that are completed by a physician or other qualified health care professional.

This policy applies to all claims submitted on a CMS 1500, UBO4 and all electronic equivalents claim form.

Reimbursement Policy

Cigna allows reimbursement for an Evaluation and Management (E/M) services:

- **Cigna utilizes the CMS 1997 coding documentation guidelines.**
- **the supporting documentation satisfies the key component criteria for the level of the Evaluation and Management service as defined by CMS in the 1997 Documentation Guidelines for Evaluation and Management Service.**

07/18/2019: Notification effective 10/19/2019 New Reimbursement Policy R30 Evaluation and Management Services. The denial of use of E/M Consultation Codes.

Cigna does not allow reimbursement for:

- **Cigna does not reimburse for outpatient or inpatient consult codes.**
- **Cigna will not reimburse professional evaluation and management (E&M) codes when billed by a facility on a UB04 claim form.**

General Background

Evaluation and Management (E/M) are services provided by a physician or other qualified healthcare professional. The Current Procedural Terminology (CPT®) describes "professional services" as face to face services that are completed by a physician or other qualified health care professional.

The current CPT evaluation and management section provides documentation guidelines including the definitions of new and established visits. The Centers Medicare & Medicaid Services (CMS) published 2 sets of documentation guidelines the 1995 and 1997 guidelines. Cigna recognizes and follows the CMS 1997 coding documentation guidelines.

Evaluation and Management codes are identified within the Current Procedural Terminology (CPT®) ranging in various types of services. Some types of service within the section are but not inclusive:

- Office visits - both established and new with descriptions
- Hospital services – inpatient and observation
- Emergency
- Preventive
- Critical Care
- Other codes that are based on location
- The codes contain descriptions and key components: history, examination, and medical decision making which are necessary for code selection.

New and Established Patients:
Cigna follows AMA's definitions of what is considered to be a new or established patients.

New Patient

Cigna follows the guidance in the CPT® and CMS, a new patient is one who has not received professional services by the same physician, or another physician within the same practice (group) within the previous 3 years.

Established Patient

Cigna follows in the CPT® and CMS, an established patient who has received professional services by the same physician, or another physician within the same practice (group) within the previous 3 years.

Consultation Codes:

Consultations services are evaluation and management services that are requested by physician/qualified healthcare professional during the care of a patient to obtain advice, or an opinion of care concerning a specific condition or problem.

Cigna will not reimburse consultation codes 99241 – 99245, and codes 99251 - 99255. Non-consultative Evaluation and Management Codes may be utilized based on the code that best describes the service performed.

07/18/2019: Notification effective 10/19/2019 New Reimbursement Policy R30 Evaluation and Management Services. The denial of use of E/M Consultation Codes.

Evaluation and Management Codes in the Facility:

Cigna will not reimburse professional evaluation and management (E&M) codes when billed by a facility on a UB04 claim form.

Multiple Patient Encounters on the Same Day

Cigna does not reimburse two E/M service codes submitted for the same date of service unless the presenting situation is one of the exception scenarios noted below. Generally, the service code with the higher Relative Value Unit (RVU) will be considered for reimbursement.* The CMS Medically Unlikely Edit (MUE) of 2 for codes 99212, 99213 and 99214 is excluded from editing as it conflicts with this reimbursement policy indicating that we only pay 1 E/M service per health care professional per single date of service.

One exception to reporting multiple patient encounters in one day is that of prolonged services with direct face-to-face patient contact (CPT® 99354, 99355). When appropriate, these codes may be used in conjunction with another E/M code for the same date of service.

Another exception to multiple patient encounter reporting is submitting a preventive medicine office visit (CPT 99381-99397) with a problem-based office visit (CPT 99201-99215). In some cases reporting both office visits may be appropriate. In these situations append modifier 25 to the E/M code that would otherwise be disallowed* to indicate a significant, separately identifiable E/M service was provided. See the *Preventive Medicine Evaluation and Management Service and Problem Based Evaluation and Management Service on the Same Day* Reimbursement Policy under the related links section at the top of this policy for more information.

Modifiers usage with Evaluation and Management Codes

Modifier 25

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

Cigna allows separate reimbursement for an Evaluation and Management (E/M) service or office visit when indicated criteria are met. See also Cigna Modifier 25 CMS/NCCI Documentation Requirement List.

Modifier 24

Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional during a Postoperative Period

Modifier 24 is used to indicate an unrelated Evaluation and Management (E/M) service that is provided during the postoperative period.

According to the Current Procedural Terminology (CPT®) manual, “the physician may need to indicate that an E/M service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service”.

Modifier 57

Modifier 57 is appended to the E/M to represent the initial decision for major surgery (global period of 090 days) that will occur either the same day or the next day. It is not appended to E/M services when the surgery is scheduled for a date in the future (e.g. 2 weeks, 3 months).

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Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Evaluation and management service codes should be selected based on their key components and contributory factors. Generally, only one E/M service code is appropriately reported per day. Because the E/M services are based on levels of complexity and components defining the services included, there is a broad range of codes from which to select the most appropriate E/M code. Only the code that most specifically represents the services provided in a particular patient encounter should be chosen to report those services

CPT®** Codes	Description
99201 - 99205	Office or other outpatient visit: new patient
99211 – 99215	Office or other outpatient visit: established patient
99218 – 99220	Initial observation care
99221 – 99223	Initial hospital care
99231 – 99233	Subsequent hospital care
99224 – 99226	Subsequent observation care
99234 – 99236	Observation or inpatient care (patient admit and discharge on the same day
99281 – 99285	Emergency department
99304 – 99306	Initial nursing facility care
99307 - 99310	Subsequent nursing facility care
99318	E/M annual nursing facility assessment
99324 – 99328	Domiciliary or rest home visit; new patient
99334 – 99337	Domiciliary or rest home visit; established patient
99341 – 99345	Home visit; new patient
99347 – 99345	Home visit; established

Not Separately Reimbursed E/M Consultation Codes for both inpatient and outpatient:

CPT®** Codes	Description
99241 – 99245	Office/outpatient Consultation; new or established patient
99251 – 99255	Inpatient Consultation; new or established patient

***Current Procedural Terminology (CPT®) ©2018 American Medical Association: Chicago, IL.**

References

1. American Medical Association. Current Procedural Terminology (CPT®) ©2018 Professional Edition.
2. CMS 1997 Documentation Guidelines for Evaluation and Management Services©
3. Deborah J. Grider, Coding with Modifiers 5th edition (Chicago, IL: American Medical Association, ©2014), 50-70.
4. Optum360, Understanding Modifiers 2018 (USA: Optum360, ©2017), 13-22.

Policy History/Update

Date	Change/Update
07/18/2019	Notification for Consultation Codes not reimbursable effective 10/19/2019