EviCore
By EVERNORTH

Peripheral Vascular Intervention (PVI) Billing Frequently Asked Questions (FAQ)

Ensuring CPT Code Accuracy for Prior Authorization Requests and Cigna Healthcare® Claims Submission

1. Why is CPT code accuracy important?

Accurate CPT code selection helps ensure that prior authorization requests match the procedure ultimately performed, reducing claim denials and reimbursement issues.

2. How are billable CPT codes organized in the authorization process?

To simplify the request process, EviCore's billable bundles combine multiple related CPT codes into a single grouping. These groupings are organized by procedure type and/or anatomical region.

3. What is the difference between a straightforward and complex lesion CPT code?

Within each procedure type, CPT codes are categorized based on the complexity of the lesion being treated:

- Straightforward lesions = stenoses
- Complex lesions = occlusions

4. Can a complex CPT code be billed for a straightforward lesion?

No. Complex CPT code cannot be billed for straightforward lesions on claims for Cigna members.

5. What should a provider do if the approved CPT code does not match the procedure that was performed?

Cigna Providers have two options:

1. If you need to change the CPT code on or before or on the DOS, contact EviCore at 866-668-9250 to request an update to the CPT code on the existing case prior to submitting the claim.
2. To change the CPT code on an existing case after the DOS **prior to submitting a claim**, please submit a new retrospective case via the web portal using the CPT code that accurately reflects the procedure performed.

6. When should a retrospective case be submitted?

A retrospective case should be submitted when the originally authorized CPT code does not accurately reflect the procedure that was ultimately performed **prior to submitting a claim**.

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7. What are the requirements for a retrospective submission?

The following criteria must be met:

- The procedure must have been performed within 15 calendar days of the original request date.
- A valid Date of Service (DOS) must be entered.

8. Why is the Date of Service (DOS) important?

The DOS determines how the request is categorized and processed within the system. Entering the correct DOS is required for accurate retrospective case handling.

9. What happens if the Date of Service is the same as the original request date?

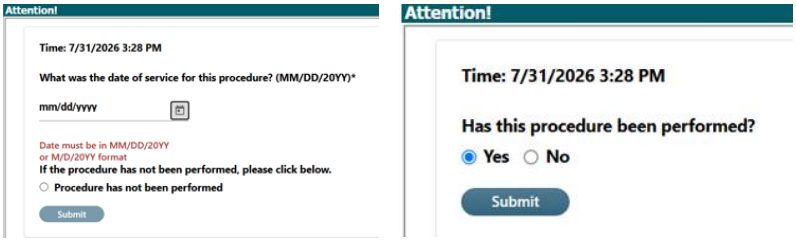
The request may appear as a routine request in the system; however, the system will process it according to retrospective case logic when appropriate.

10. Will submitting a retrospective case affect existing approvals?

No. A new case will be created to reflect the updated CPT code, and any previously issued approvals for other CPT codes related to the case will remain in effect.

11. How does the system determine whether a case is Routine or Retrospective?

- Routine Case: Created before or on the same day the procedure is performed.
- Retrospective Case: Created after the procedure date but within 15 calendar days of the procedure.



12. What is the best way to avoid reimbursement delays?

Ensure the CPT code submitted for authorization accurately reflects the expected procedure and update the authorization promptly if the procedure performed differs from the original request.

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Need Assistance?

- For the full CPT code list and guide, access **Cigna Provider Resources | EviCore by Evernorth** and navigate to **Solution Resource** and select **Cardiac & Vascular Intervention**
- For CPT code updates or questions regarding an existing Cigna authorization, contact EviCore at 866-668-9250.
- For assistance with membership, claims, provider network issues, etc., submit the issue to our dedicated teams via **EviCore Communication Relationship Management (ECRM):**
  - **Access: ECRM Services**
  - **ECRM educational resources: ECRM Resources | EviCore by Evernorth**
  - **Trouble using ECRM? Send an email to: ECRMSupport@EviCore.com**