



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

Subject Ambulatory Blood Pressure
Monitoring with Automatic
Portable Monitors

Effective Date 6/15/2011
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Hyperlink to Related Coverage Policies

Cardiac Event Monitors
Home Sphygmomanometers

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer'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 these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2011 CIGNA

Coverage Policy

CIGNA covers ambulatory blood pressure monitoring (ABPM) over a 24-hour period as medically necessary for ANY of the following:

- suspected white coat hypertension (WCH) (three in-office blood pressure [BP] readings of > 140/90 mm Hg and two out-of-office BP readings of < 140/90) with no evidence of end organ damage
- resistant hypertension in an individual who is being treated with three or more medications
- episodic hypertension suspected when office BP measurements are normal and symptoms (excessive sweating, palpitations, apprehension) suggest episodic hypertension secondary to an existing condition
- hypertensive individual with hypotensive symptoms thought to be related to antihypertensive medications or neurological syndromes
- suspected masked hypertension
- suspected nocturnal hypertension (i.e., nondipper)
- when there is a large discrepancy between clinic and home BP measurements
- management of isolated systolic hypertension in an individual age 60 or older

CIGNA does not cover ABPM for ANY other indication because it is considered not medically necessary.

General Background

Elevated blood pressure (BP), also termed hypertension, is a risk factor for cardiovascular diseases and kidney disease. The National Heart, Lung, and Blood Institute's (NHLBI) Joint National Committee (JNC) on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure defines hypertension as: stage one, systolic pressure of 140–159 mm Hg or diastolic pressure of 90–99 mm Hg; or stage two, systolic pressure greater than or equal to 160 mm Hg, or diastolic pressure greater than or equal to 100 mg Hg (NHLBI, 2004).

Blood pressures are characterized by a clear circadian pattern with values tending to peak during the daytime hours and then fall after midnight. In the early morning hours, BP sharply increases, with daytime levels being reached within a relatively short period. Activity of subjects at the time of BP recording is an important determinant of the level of BP and may affect hypertensive disease (Chobanian, et al., 2003).

BP as recorded in the office setting is the standard technique recommended for the measurement of BP in routine medical care. Clinic BP measurements have limitations even when measured by established guidelines. One limitation is that BP measured in the clinic may not be the same as BP outside the clinic setting. When BP rises in the clinic setting in response to the observer and/or other aspects of the medical environment, it is known as "white coat" hypertension (WCH). The difference between measurements obtained in- and outside the clinic setting can lead to confusion about the diagnosis of hypertension and the need to start or modify therapy. Ambulatory blood pressure monitoring (ABPM) allows for the identification of those patients whose nocturnal BP does not fall, so called "nondippers." It is reported that these patients have a higher risk of developing complications from their hypertension. More recently, another type of hypertension has been recognized on ambulatory monitoring, so-called "masked hypertension" where values are consistently higher at home than in the physician's office (Treadway, 2008; Ohkubo, et al., 2005).

ABPM differs from self-BP monitoring. Self-BP monitoring is performed by a patient using standard BP monitoring equipment (may be manual or digital) and is performed at determined times. ABPM is a noninvasive technique by which multiple indirect BP readings can be obtained automatically over a 24-hour period. Usually, the heart rate and BP will be measured at 15- to 30-minute periods during the day and every 30 minutes to one hour at night. The total number of readings varies between 50 and 100. ABPM devices consist of an inflatable cuff with pressure regulators and valves to measure BP, a cuff microphone or sound transducer and microprocessor to detect and interpret BP sounds, mechanisms for programming and recording BP readings, and an inflation bulb for semiautomatic devices. There are several types of devices including: fully automated, which inflate at pre-programmed intervals; semi-automated, which are patient-activated; and trans-telephonic, which allow the use of telephones to transmit measured automatic digital readings to a computer-assisted receiver. The devices are lightweight and quiet and use auscultatory or oscillometric methods, or both. The monitors can be attached by a trained technician. A series of calibration readings are taken with a mercury sphygmomanometer to ensure the device is giving accurate readings. It has been reported that ABPM patients whose 24-hour BP exceeded 135/85 mm Hg were nearly twice as likely to have a cardiovascular event as those with 24-hour mean BPs < 135/85 mmHg, irrespective of the level of the office BP (Pickering, et al., 2005; Clement, et al., 2003; Ernst, et al., 2002; Verdecchia 2000).

U.S. Food and Drug Administration (FDA)

Both semiautomated and fully-automated ABPM monitors are categorized as Class II devices. The FDA has published guidelines regarding the 510(k) approval of noninvasive BP monitors. The guidelines apply to monitors covered by the American National Standards Institute (ANSI) and the Association for the Advancement of Medical Instrumentation (AAMI) for electronic or automated sphygmomanometers (SP10 standard). Included in the SP10 standard are automated noninvasive BP monitors that measure pressure at the arm, finger, or wrist using a standard oscillometric measurement method (FDA, 2006).

Literature Review

Evidence in the published, peer-reviewed scientific literature indicates that automated ABPM is a safe and reliable technique for determining average blood pressure values in a 24-hour period and identifying blood pressure variability throughout an observation period. Evidence in the peer-reviewed medical literature suggests that ABPM is indicated for the management of a selected subset of patients. ABPM is indicated for the evaluation of WCH in the absence of target-organ injury. ABPM is used to assess patients with hypotensive symptoms with antihypertensive medications, resistant hypertension, episodic hypertension and autonomic dysfunction, suspected masked hypertension, suspected nocturnal hypertension, when there is a large discrepancy between clinic and home BP measurements, and for the management of isolated systolic hypertension in patients age 60 or older (Bakris, et al., 2010; Dawes, et al., 2006; Ingelsson, et al, 2006;

Paoletti, et al., 2006; Agarwal, et al., 2006; Ohkubo, et al., 2005; Bobrie, et al, 2004; Staessen, et al., 2004; Clement, et al., 2003; Staessen, et al., 1999).

Systematic Reviews and Guidelines

The Institute for Clinical Systems Improvement (ICSI) guideline on hypertension diagnosis and treatment states, “standardized BP measurement techniques, including out of office or home BP measurements, should be employed when confirming an initially elevated BP and for all subsequent measures during follow-up and treatment for hypertension” (ICSI, 2010).

The National Institute for Excellence (NICE) clinical guideline on management of hypertension in adults in primary care advises to identify hypertension (persistent raised BP above 140/90 mmHg), the patient must return for at least two subsequent clinic visits where their BP is assessed from two readings using the best conditions available. The routine use of automated ABPM or home monitoring devices in primary care is not currently recommended because their value has not been adequately established; appropriate use in primary care remains an issue for further research (NICE, 2006).

Goyal et al. (2005) conducted a systematic review of the literature to evaluate the role of ABPM in heart failure. The authors report ABPM has established its use in the definition of WCH and monitoring of essential hypertension; however, more prospective controlled studies in patients with congestive heart failure need to be conducted to define the impact of treatments on circadian BP profile.

Bergel et al. (2002) reported in a Cochrane review of ambulatory versus conventional method for monitoring BP during pregnancy. No randomized controlled trials provided evidence to support the use of ABPM during pregnancy.

Professional Societies/Organizations

In 2008, the American Heart Association (AHA) Professional Education Committee of the Council for High Blood Pressure Research published a Scientific Statement on resistant hypertension evaluation, diagnosis and treatment. The committee recommends that 24-hour ABPM be utilized when clinic BP measurements are consistently higher than out-of-office measurements; in patients who repetitively show signs of overtreatment, particularly orthostatic symptoms; and in patients with chronically high office BP values but an absence of target organ damage (left ventricular hypertrophy, retinopathy, chronic kidney disease). A mean ambulatory daytime BP of > 135/85 mm Hg is considered elevated. If a significant white-coat effect is confirmed, out-of-office measurements should be relied on to adjust treatment (Calhoun, et al., 2008). This statement has not been updated since 2008.

The AHA Scientific Statement recommendations for BP measurement states 24-hour ambulatory monitoring gives a better prediction of risk than office measurements and is useful for diagnosing WCH. Other potential applications of ABPM include the identification of individuals with a nondipping BP pattern (e.g., in diabetes), refractory hypertension with little target organ damage, suspected autonomic neuropathy, and patients in whom there is a large discrepancy between clinic and home measurements (Pickering, et al., 2005). This statement has not been updated since 2005.

Practice guidelines of the European Society of Hypertension for clinic, ambulatory and self-BP measurement accepted clinical indications for ABPM include: suspected WCH, nocturnal hypertension and masked hypertension; to establish dipper status, resistant hypertension, and hypertension of pregnancy. Potential indications for ABPM include: elderly patient; as a guide to antihypertensive drug treatment; type I diabetes; evaluation of symptoms suggesting orthostatic hypotension; autonomic failure (O'Brien, et al., 2005). This guideline has not been updated since 2005.

The National Heart, Lung, and Blood Institute's (NHLBI) Joint National Committee (JNC) on Detection, Evaluation, and Treatment of High Blood Pressure states in its seventh report that APBM is warranted for the evaluation of WCH in the absence of target organ injury. ABPM is also helpful to assess patients with apparent drug resistance hypertension (i.e., failure to achieve goal BP in patients who are adhering to full doses of an appropriate three-drug regimen that includes a diuretic), hypotensive symptoms with antihypertensive medications, episodic hypertension, and autonomic dysfunction. ABPM also provides a measure of the percentage of BP readings that are elevated, overall BP load, and the extent of BP reduction during sleep. BP in most individuals decreases by 10%–20% during the night. There is an increased risk for cardiovascular events

for those individuals who do not have a decrease in BP at night (NHLBI, 2004). This report has not been updated since 2004.

In a statement by the U.S. Preventive Services Task Force (USPSTF) summarizing recommendations on screening for high BP, ABPM was found to be a better predictor of clinical cardiovascular outcome than clinic-based approaches. The USPSTF states, “due to the limitations in the reliability of BP measurements, experts commonly recommend that clinicians diagnose hypertension only after obtaining two or more elevated readings at two or more office visits at intervals of one to several weeks” (USPSTF, 2003). This statement has not been updated since 2003.

Summary

Ambulatory blood pressure monitoring (ABPM) provides information about blood pressure (BP) during daily activities and sleep. ABPM can have predictive value for cardiovascular events and adds to the predictive value of office BP measurements. Professional organizations and evidence in the peer-reviewed medical literature suggests that ABPM is indicated for the management of a selected subset of patients. ABPM is indicated for the evaluation of white-coat hypertension (WCH) in the absence of target-organ injury. ABPM is used to assess patients with hypotensive symptoms with antihypertensive medications, resistant hypertension, episodic hypertension and autonomic dysfunction, suspected masked hypertension, suspected nocturnal hypertension, when there is a large discrepancy between clinic and home BP measurements, and for the management of isolated systolic hypertension in patients age 60 or older.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT [®] * Codes	Description
93784	Ambulatory blood pressure monitoring utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer, including recording, scanning analysis, interpretation and report.
93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only
93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report
93790	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report

ICD-9-CM Diagnosis Codes	Description
401.0-405.99	Hypertensive disease
458.0	Orthostatic hypotension
780.2	Syncope and collapse
780.4	Dizziness and giddiness
785.1	Palpitations
796.2	Elevated blood pressure reading without diagnosis of hypertension

Experimental/Investigational/Unproven/Not Covered:

ICD-9-CM Diagnosis Codes	Description
	All other codes

References

1. Agarwal R, Andersen MJ. Prognostic importance of ambulatory blood pressure recordings in patients with chronic kidney disease. *Kidney Int.* 2006 Apr;69(7):1175-80.
2. Appel L Robinson K, Guallar E. Utility of Blood Pressure Monitoring Outside of the Clinic Setting. Evidence Report/Technology Assessment No. 63 (Prepared by the Johns Hopkins Evidence-based Practice Center under Contract No. 290-97-006). Publication No. 03-004. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ). November 2002. Accessed April 18, 2011. Available at URL address: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat1a.chapter.799>
3. Bakris GL, Lindholm LH, Black HR, Krum H, Linas S, Linseman JV, et al. Divergent results using clinic and ambulatory blood pressures: report of a darusentan-resistant hypertension trial. *Hypertension.* 2010 Nov;56(5):824-30.
4. Bergel E, Carole G, Althabe F. Ambulatory versus conventional methods for monitoring blood pressure during pregnancy (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2002.
5. Bobrie G, Chatelier G, Genes N, Clerson P, Vaur L, Vaisse B, et al. Cardiovascular prognosis of "Masked Hypertension" detected by blood pressure self-measurement in elderly treated hypertensive patients. *JAMA.* 2004;291(11):1342-9.
6. Calhoun DA, Jones D, Textor S, Goff DC, Murphy TP, Toto RD, et al.; American Heart Association Professional Education Committee. Resistant hypertension: diagnosis, evaluation, and treatment: a scientific statement from the American Heart Association Professional Education Committee of the Council for High Blood Pressure Research. *Circulation.* 2008 Jun 24;117(25):e510-26.
7. Centers for Medicare & Medicaid Services (CMS). NCD for ambulatory blood pressure monitoring (20.19). July 1, 2003. Accessed April 18, 2011. Available at URL address: http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=20.19&ncd_version=2&basket=ncd%3A20%2E19%3A2%3AAmbulatory+Blood+Pressure+Monitoring
8. Centers for Medicare & Medicaid Services (CMS). Technology Assessments for ambulatory blood pressure monitoring (CAG-00067N). February 2001. Accessed April 18, 2011. Available at URL address: <http://www.cms.hhs.gov/mcd/viewtechassess.asp?id=5>
9. Chobanian A, Bakris G, Cushman E, Green W, Izzo J, Jones D, et al. The seventh report of the joint national committee on prevention, detection, evaluation and the treatment of high blood pressure. *JAMA.* 2003;289(19):2560-73.
10. Clement DL, Buyzere M, Duprez D, DeBacuquer DA, de Leeuw PW, Fagard RH. Prognostic value of ambulatory blood-pressure recordings in patients with treated hypertension. *N Engl J Med.* 2003;348(24):2407-15.
11. Dawes MG, Coats AJ, Juszczak E. Daytime ambulatory systolic blood pressure is more effective at predicting mortality than clinic blood pressure. *Blood Press Monit.* 2006 Jun;11(3):111-8.
12. ECRI Institute. Hotline Response [database online]. Plymouth Meeting (PA): ECRI Institute; 2008 June 11. Continuous ambulatory blood pressure monitoring. Available at URL address: <http://www.ecri.org>
13. Ernst M, Bergus G. Noninvasive 24-hour ambulatory blood pressure monitoring: Overview of technology and clinical applications. *Pharmacotherapy.* 2002;22(5):597-612.

14. Food and Drug Administration (FDA). Center for Devices and Radiological Health (CDRH). 510(k) Database. Updated April 7, 2011. Accessed April 18, 2011. Available at URL address: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm>
15. Frost BK, Hajjar IM. Improving patient outcomes with ambulatory blood pressure monitoring in elderly with hypertension. *J Am Acad Nurse Pract.* 2006 Mar;18(3):104-15.
16. Goyal D, Macfadyen RJ, Watson RD, Lip GY. Ambulatory blood pressure monitoring in heart failure: a systematic review. *Eur J Heart Fail.* 2005 Mar 2;7(2):149-56.
17. Ingelsson E, Bjorklund-Bodegard K, Lind L, Arnlov J, Sundstrom J. Diurnal blood pressure pattern and risk of congestive heart failure. *JAMA.* 2006 Jun 28;295(24):2859-66.
18. Institute for Clinical Systems Improvement (ICSI). Clinical Care Guideline: Hypertension Diagnosis and Treatment. Updated November 2010. Accessed April 18, 2011. Available at URL address: <http://www.icsi.org/index.aspx>
19. Mallion JM, Baguet JP, Mancia G. European Society of Hypertension Scientific Newsletter: Clinical value of ambulatory blood pressure monitoring. *J Hypertens.* 2006 Nov;24(11):2327-30.
20. Marchando R, Elston M. Automated ambulatory blood pressure monitoring: clinical utility in the family practice setting. *Am Fam Phys.* 2003;67(11):2343-50.
21. National Heart, Lung, and Blood Institute (NHLBI). Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (JNC). National Institutes of Health (NIH). NIH Publication No. 04-5230. August 2004. The Seventh Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7). Accessed April 18, 2011. Available at URL address: <http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf>
22. National Institute for Clinical Excellence (NICE). Management of hypertension in adults in primary care. Clinical Guideline 34. London, UK: NICE; June 28, 2006. Accessed April 18, 2011. Available at: <http://www.nice.org.uk/>
23. Niiranen TJ, Kantola IM, Vesalainen R, Johansson J, Ruuska MJ. A comparison of home measurement and ambulatory monitoring of blood pressure in the adjustment of antihypertensive treatment. *Am J Hypertens.* 2006 May;19(5):468-74.
24. [No authors listed]. Automated ambulatory blood pressure devices and self-measured blood pressure monitoring devices: their role in the diagnosis and management of hypertension. *American College of Physicians. Ann Intern Med.* 1993 Jun 1;118(11):889-92.
25. O'Brien E, Asmar R, Beilin L, Imai Y, Mancia G, Mengden T. Practice guidelines of the European Society of Hypertension for clinic, ambulatory and self blood pressure measurement. *J Hypertens.* 2005 Apr;23(4):697-701.
26. Ohkubo T, Kikuya M, Metoki H, Asayama K, Obara T, Hashimoto J, Totsune K, Hoshi H, Satoh H, Imai Y. Prognosis of "masked" hypertension and "white-coat" hypertension detected by 24-h ambulatory blood pressure monitoring 10-year follow-up from the Ohasama study. *J Am Coll Cardiol.* 2005 Aug 2;46(3):508-15.
27. Padwal RS, Hemmelgarn BR, Khan NA, Grover S, McKay DW, Wilson T, et al.; Canadian Hypertension Education Program. The 2009 Canadian Hypertension Education Program recommendations for the management of hypertension: Part 1--blood pressure measurement, diagnosis and assessment of risk. *Can J Cardiol.* 2009 May;25(5):279-86.
28. Paoletti E, Bellino D, Amidone M, Rolla D, Cannella G. Relationship between arterial hypertension and renal damage in chronic kidney disease: insights from ABPM. *J Nephrol.* 2006 Nov-Dec;19(6):778-82.

29. Papadopoulos DP, Papademetriou V. Resistant hypertension: diagnosis and management. *J Cardiovasc Pharmacol Ther.* 2006 Jun;11(2):113-8.
30. Pickering TG, Hall JE, Appel LJ, Falkner BE, Graves J, Hill MN, et al. Recommendations for blood pressure measurement in humans and experimental animals: part 1: blood pressure measurement in humans: a statement for professionals from the Subcommittee of Professional and Public Education of the American Heart Association Council on High Blood Pressure Research. *Circulation.* 2005 Feb 8;111(5):697-716.
31. Pickering TG, Shimbo D, Haas D. Ambulatory blood-pressure monitoring. *N Engl J Med.* 2006 Jun 1;354(22):2368-74.
32. Staessen J, Hond E, Celis H, Fagard R, Keary L, Vanderhoven G, O'Brien E. Antihypertensive treatment based on blood pressure measurement at home or in the physicians office. *JAMA.* 2004;291(8):955-64.
33. Stassen J, Thijis L, Fagard R, O'Brien E, Clement D, Leeuw P, et al. Predicting cardiovascular risk using conventional vs. ambulatory blood pressure in older patients with systolic hypertension. *JAMA.* 1999;282(6):539-46.
34. Tice JA. Utility of ambulatory blood pressure monitoring. *Technology Assessment.* San Francisco, CA: California Technology Assessment Forum (CTAF); October 20, 2004. Accessed April 18, 2011. Available at: <http://ctaf.org/section/assessment/>
35. Treadway KK. Evaluation of hypertension. In: Goroll AH, Mulley AG, editors. *Primary care medicine: office evaluation and management of the adult patient.* 6th ed. Philadelphia, PA; Lippincott Williams & Wilkins; 2008. Ch 19.
36. U.S. Preventive Services Task Force (USPSTF). Screening for High Blood Pressure: Recommendations and Rationale. June 2003. Current as of December 2007. Agency for Healthcare Research and Quality, Rockville, MD. Accessed April 18, 2011. Available at URL address: <http://www.ahrq.gov/clinic/uspstf07/hbp/hbprs.htm>
37. Urbina E, Alpert B, Flynn J, Hayman L, Harshfield GA, Jacobson M, et al.; American Heart Association Atherosclerosis, Hypertension, and Obesity in Youth Committee. Ambulatory blood pressure monitoring in children and adolescents: recommendations for standard assessment: a scientific statement from the American Heart Association Atherosclerosis, Hypertension, and Obesity in Youth Committee of the council on cardiovascular disease in the young and the council for high blood pressure research. *Hypertension.* 2008 Sep;52(3):433-51.
38. Verdecchia P. Prognostic value of ambulatory blood pressure. Current evidence and clinical implications. *Hypertension.* 2000;35(3):844-51.
39. White W. Ambulatory blood pressure monitoring in clinical practice. *NEJM.* 2003;348(24):2377-8.
40. White WB, Giles T, Bakris GL, Neutel JM, Davidai G, Weber MA. Measuring the efficacy of antihypertensive therapy by ambulatory blood pressure monitoring in the primary care setting. *Am Heart J.* 2006 Jan;151(1):176-84.

Policy History

<u>Pre-Merger Organizations</u>	<u>Last Review Date</u>	<u>Policy Number</u>	<u>Title</u>
CIGNA HealthCare	6/15/2007	0078	Ambulatory Blood Pressure Monitoring with Automatic Portable Monitors

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