

2005



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A Business of Caring.

FOR CIGNA PARTICIPATING PROVIDERS

As outlined in the September issue of the *2005 Alert*, **effective January 2005, CIGNA is making a number of changes to our programs and processes** that will affect you as you care for CIGNA members.* This issue summarizes the key changes and provides more information about some of the new programs and processes. With this issue we've also enclosed a 2005 ID card reference sheet.

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As of December 15, 2004, CIGNA for Health Care Professionals, our secure website for health care professionals and their designated office staff, has been updated to reflect 2005 changes. This site offers access to detailed information on CIGNA policies and procedures, such as precertification requirements; member benefit plans and eligibility; claim inquiry and much more in an easy-to-use dynamic tool. Register today for this time-saving tool at www.cignaforhcp.com.

For a copy of the September *2005 Alert*, visit our website at www.cigna.com/health/provider, or call your local Provider Services Department.

*Changes described in this *2005 Alert* do not apply to all CIGNA HealthCare members, effective January 1, 2005. Changes will become effective for some CIGNA HealthCare members during 2005 and 2006. Please check your patient's benefit plan.

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In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare of Virginia, Inc. and CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

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Key 2005 Changes and Precertification Requirements

- **Two New Medical Management Models.*** The type of plan a member participates in — for example, an HMO or PPO plan — will no longer determine the type of medical management that applies. Instead, employers may choose one of two new medical management models — Personal Health Solutions (PHS) or Personal Health Solutions Plus (PHS+) — regardless of the medical product they choose. Key requirements for each model include:

Medical Management Model	Personal Health Solutions (PHS)	Personal Health Solutions Plus (PHS+)
Precertification	<p>Required for all inpatient services, including:</p> <ul style="list-style-type: none"> • acute care hospitals • long-term care hospitals • inpatient rehabilitation • skilled nursing facilities • inpatient hospice <p>Medical observation stays also require precertification.</p>	<p>All requirements of PHS PLUS</p> <p>Precertification required for certain outpatient procedures and services.</p> <p>A complete list of updated outpatient precertification requirements is available on www.cignaforhcp.com.</p>
Continued Stay Review	Generally begins on day 2, depending on diagnosis.	Generally begins on day 1, depending on diagnosis.

- **Updated outpatient precertification requirements.*** A complete list of precertification requirements is available on our secure provider website at www.cignaforhcp.com.
- **Changes to standard covered services and benefits.** See September issue of *2005 Alert* at www.cigna.com/health/provider.
- **Standardized Administration of Precertification Process.*** Providers are responsible for obtaining precertification of coverage for all in-network services requiring precertification for all products.
- **Alternate Member Identifier (AMI).** We will begin rollout of this CIGNA-generated identifier to replace the subscriber's Social Security Number (SSN) on member ID cards. The AMI will consist of one letter and eight numbers. Providers may use the subscriber SSN or the AMI to submit a claim.

Note: In certain locations, CIGNA HealthCare maintains a relationship with various delegated entities for outpatient services, such as radiology, physical/occupational therapy and chiropractic care. **Providers and/or referring physicians must continue to contact the appropriate delegated entity for precertification of these services where applicable.**

* Does not apply to provider groups to which CIGNA HealthCare has delegated responsibility for utilization management under a risk contract. If you participate in such a group, please continue to follow your group's processes.

Centers of Excellence Program*

Our Centers of Excellence Hospital Value Profile program supports the growing consumer demand for information on hospital outcomes and efficiency for specific diagnoses and procedures. Through this program, participating hospitals will have both a patient-outcomes and cost-efficiency score for each of 22 procedures/conditions – one, two or three stars – on our online provider directory. More stars mean a higher score on a particular measure. In some instances, such as where data is not available, the directory will indicate *Not Rated*. Physicians will not be rated under this program. CIGNA is targeting 22 procedures based on volume, variability of results and consumer interest.

A Center of Excellence is a hospital that has achieved the highest score for both patient outcomes (three stars) and cost efficiency (three stars) for a particular procedure or condition. Each hospital is scored by procedure, so a hospital may be a Center of Excellence for one or more procedures. Center of Excellence hospitals will be identified in the online provider directory.

Since we are comparing hospitals nationally, there may be times where there is no Center of Excellence for a specific procedure in a given location. However, all CIGNA HealthCare participating facilities are regularly reviewed against our quality standards, and the lack of a Center of Excellence designation does not indicate that a hospital is not a quality provider of health care services.

Members are not required to use a Center of Excellence facility. The Centers of Excellence program simply gives our members information they can consider as they make decisions about where to seek care.

*The Centers of Excellence program may not apply in all geographic areas.

CIGNA Choice FundSM

CIGNA Choice Fund packages a consumer health care fund with an underlying PPO or Open Access Plus medical plan that has a deductible, coinsurance and out-of-pocket maximum.



There are two Choice Fund options — a Choice Fund Health Reimbursement Arrangement (HRA) and the new federally-created Choice Fund Health Savings Account (HSA). Both of these options include a consumer fund that can help members pay the portion of health care expenses they are responsible for, as defined by their underlying medical plan. For some plans, the consumer fund may also be available to pay for expenses that are not covered by the underlying medical plan, such as pharmacy costs, dental expenses or vision expenses.

Unused Choice Fund dollars are available to help members offset their health care costs in future years. This allows members to build up their consumer fund over time through careful management of their health care expenses.

Choice Fund Payment

The claim submission process for Choice Fund is basically the same as for any plan with deductibles and coinsurance. (These plans generally do not have copayments.) You submit the claim to CIGNA without collecting deductibles or coinsurance at the time of service. The member's responsibility is determined by CIGNA, based on the terms of the underlying medical plan.

Choice Fund HRA – when there are funds available and the service is eligible to be paid by the HRA, you will automatically receive payment directly from CIGNA on behalf of the member from the Choice Fund HRA. After funds have been used, you will bill the member for any remaining member responsibility.

Choice Fund HSA - members may choose to use their HSA funds to pay providers, or they may elect to pay with non-HSA funds. You will bill the member for any member responsibility. Members can access HSA funds with a debit card or a check that draws directly from the HSA account to pay their final responsibility. Beginning in April 2005, members may elect to have CIGNA pay providers automatically from their Choice Fund HSA, as part of the standard medical claim processing. >>> *For reimbursement process, see page 4.*

Choice Fund Reimbursement Process

1. As with all plans with deductibles and coinsurance, you should not collect deductibles or coinsurance at the time of service.
2. Submit the claim as usual.
3. The member responsibility will be determined by the claim adjudication under the terms of the medical plan.
4. You will receive a standard Explanation of Payment (EOP) from the medical claim system.
If the medical plan EOP has the following remark code: "Final payment determination will follow the review of available funds in a CIGNA Choice Fund Health Reimbursement Arrangement or Flexible Spending Account," then the remaining member responsibility has been sent to the Choice Fund for consideration.
 - You will receive a second EOP (and a check if funds are available) from CIGNA Choice Fund along with the final member responsibility. You may receive both EOPs on the same day or a few days apart.
 - You will need to review the EOPs to determine final member responsibility. You may then bill the member for the final responsibility.
5. If the medical plan EOP does not include the above remark code:
 - The remaining member responsibility has not been sent to the Choice Fund system.
 - You may bill the member for the final member responsibility shown on the medical plan EOP.
6. Some Choice Fund participants may use special Choice Fund debit cards and/or checks to pay for eligible expenses from their fund.
7. Note that checks are processed from the Choice Fund daily.

What You Need to do Differently in 2005

- You will need to determine whether your patient's plan requires only inpatient precertification or both inpatient and outpatient precertification, **as you can no longer assume which services require precertification based on the product a patient has.** You can do this in several ways:
 - ✓ Check the back of the member's card – Most cards will say "Inpatient admission," or "Inpatient admission and outpatient procedures." Note that some members will not receive new cards until later in the year when their employer renews. So you may need to check the patient's precertification requirements through our secure website or by phone, as outlined below.
 - ✓ Check the member's benefits on our secure website at www.cignaforhcp.com The type of medical management is listed as PHS (inpatient precertification only required) or PHS+ (inpatient and outpatient precertification required).
 - ✓ Check the member's precertification requirements by calling 1.800.88CIGNA (1.800.882.4462) or by calling member services at the toll-free number listed on the back of the member's ID card. The Interactive Voice Response System will indicate "inpatient precertification" or "inpatient and outpatient precertification."
- **Providers are responsible for obtaining precertification of coverage for all in-network services requiring precertification for all products.** Requests for routine precertification should be directed to CIGNA HealthCare at least 72 hours before the scheduled service.
- Check our website at www.cignaforhcp.com for a complete list of procedure codes requiring precertification.
- Do not collect deductibles or coinsurance at the time of service. Wait until you receive the Explanation of Payment(s) (EOP) showing the final member responsibility before you bill the member. See reimbursement process above.