

How the CIGNA Settlement Agreement helps the physician practice

The CIGNA HealthCare (CIGNA) Settlement Agreement (“Settlement”) provides for greater transparency in CIGNA’s claims processing and payment practices. Through this Settlement, CIGNA has committed to disclose certain business practices and update its administrative and claims processing systems. Additionally, contracts provided by CIGNA to physicians in its provider network must conform to the Settlement.

Physicians should review all future CIGNA contracts to make sure they include a clear written representation that the proposed contract does not waive or conflict with any of the business practice initiatives that CIGNA has agreed to implement under the Settlement. An example of such language is:

CIGNA represents that nothing in this contract waives or conflicts with any of the business practice initiatives it has agreed to undertake pursuant to the Settlement Agreement dated as of September 4, 2003, *In Re: Managed Care Litigation, MDL No.: 00-1334-MD-MORENO*.

Under the Settlement, certain business practices are prohibited such as: the inclusion of “gag clauses” in provider contracts, as well as restrictions on stop-loss coverage from other insurers, “all products clauses,” restrictions on balance billing and termination of contract without cause. However, it must be underscored that physicians can waive the protections that are contained in the Settlement.

If a physician receives and signs a contract with terms that are inconsistent with the Settlement, the Settlement protections may be waived. Physicians should consult with their attorney before agreeing to waive any protections provided in the Settlement. Physicians should consider asking CIGNA to identify and to explain in writing, each provision in the physician’s contract that is inconsistent with the Settlement. Signing a contract that is inconsistent with the Settlement could result in a waiver by the physician of the protections provided to the physician in the Settlement.

Physicians should note that the Settlement provides that if state law offers more protection than the Settlement, then state law applies. Physicians need to be aware of relevant state laws and regulations, particularly in the area of prompt payment of claims, to ensure they receive all available protections.

Physicians should review **all** contracts from every payer to understand the implications of the contract on their practices before signing any contract. The American Medical Association (AMA) [Model Managed Care Contract](#) (PDF, 453KB) contains sample contract language designed to assist physicians in avoiding common contracting pitfalls.

This flyer does **not** summarize or identify all of the protections provided in the Settlement. Physicians are encouraged to download the Settlement from www.hmosettlements.com or obtain additional information, including compliance dispute processes, from the AMA Web site at www.ama-assn.org/go/settlements. Physicians may consider filing a compliance dispute if prohibited clauses are contained in a contract submitted by CIGNA or CIGNA fails to adhere to the terms of the Settlement.

Summary of “key” CIGNA settlement provisions

Coding rules

- CIGNA shall comply with most AMA Current Procedural Terminology (CPT®)* codes, guidelines and conventions, unless otherwise identified on CIGNA’s physician Web site.
- No automatic downcoding of any evaluation and management (E/M) CPT code for covered services.
- If a bill contains a CPT code for the performance of an E/M CPT code appended with an appropriate modifier (e.g., modifier 25 and 57) and a CPT code for the performance of a non-E/M service procedure code, both codes will be recognized and eligible for payment.
- A CPT code will not be automatically changed to another CPT code reflecting a reduced intensity of the service when such CPT code is one of a series of codes that differentiates among simple, intermediate and complex.
- A CPT code appended with a CPT modifier 59 will be recognized and separately eligible for payment to the extent that it designates a distinct or independent procedure performed on the same day by the same physician.
- No CPT modifier 51 exempt CPT codes are subject to the multiple procedure reduction logic or rule.
- Supervision and interpretation CPT codes are separately identifiable and eligible for payment.
- “Add-on” codes, as designated by CPT, will be recognized and eligible for payment as separate codes and shall not be subject to the multiple procedure logic or rule.
- Recommended vaccines and injectibles, as well as the administration of these vaccines and injectibles, will be reimbursed.
- No global period for surgical procedures will be longer than any period designated on a national basis by the Centers for Medicare and Medicaid Services (CMS) for such surgical procedures.

Disclosure of fee schedule information, claim coding and payment policies

- Physician fee schedules shall be made available to all contracted physicians upon request of specific CPT codes via email and can be changed only once a year by CIGNA.
- CIGNA will not rent its physician networks to any other managed care company or health insurer that is not a subsidiary, for the purpose of providing health care services or supplies to any person who is not a plan member.
- Physicians will be given 90 days advance notice of all planned Material Adverse Changes to CIGNA’s policies and procedures affecting performance under contracts with participating physicians.
- CIGNA will respond within 10 days to inquiries regarding fee schedule, claim coding and bundling edits, covered services and clinical guideline information that are sent to the established electronic mail address.
- “Payment in full” or other restrictive endorsement on a payment by CIGNA is not binding and can be appealed.
- Copies of contracts will be provided to physicians upon written request.

* CPT is a registered trademark of the American Medical Association.

- Capitation fees will be paid retroactive to the date of enrollment, when a patient chooses a primary care physician (PCP) or is assigned to a PCP.
- CIGNA shall provide physicians who are paid on a capitation basis with monthly reports within 10 business days after the beginning of each month. These reports will include membership information to allow reconciliation of capitation payments.

Prompt payment requirements

- CIGNA is required to process and finalize payment for claims within 30 calendar days following the submission of all necessary information within the first year of Final Approval. After the first year, CIGNA is required to process and finalize payment of claims within 15 business days following the submission of all necessary information for claims submitted electronically.
- Interest will be paid at 6 percent on delayed claims.

Overpayment recovery

Overpayment recovery efforts will not be initiated more than 12 months after the original payment. A 30 day written notice will be provided to the physician prior to initiating an overpayment recovery effort (other than for recovery of duplicate payments).

Medically necessary or medical necessity definition

- No retroactive retraction of a pre-certified medically necessary determination.
- CIGNA accepts the following definition of medical necessity:

“Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and c) not primarily for the convenience of the patient or physician, or other physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors. Preventive care may be medically necessary, but coverage for medically necessary preventive care is governed by the terms of the applicable plan documents.

Arbitration

Arbitration fees for solo and small group physician practices are capped at \$1,000.

New physician credentialing

New physician group members will be credentialed within 90 days of the receipt of the application. Physicians also can submit an application prior to their employment.

For additional information, visit the AMA Private Sector Advocacy (PSA) Web site at www.ama-assn.org/go/psa or call (800) 621-8335 and ask for PSA.