

SECTION 3

Care Management Program





Care Advocacy Program

This section highlights CIGNA's care management program, Care Advocacy, and the associated expectations of practitioners. Care Management is monitored through CIGNA's Regional Care Centers (RCCs) and National Care Center (NCC). Care Advocacy represents a streamlined system that targets specific clinical categories where intervention or outreach can add value to the therapeutic process. CIGNA applies our Care Advocacy philosophy to inpatient and outpatient case management, and has reengineered the care management model to provide targeted, proactive interventions for all levels of care. Program features include:

Outpatient

- No preauthorization for routine outpatient care
- Consumer driven—participants can pick a network practitioner and self-refer
- Systematic clinical identification of participants with either complex illnesses or high risk factors, allowing CIGNA to intervene only when or where appropriate and effective
- Detailed benefit education—helping participants navigate the healthcare system
- Coordination of care—facilitating relationships among various members of the behavioral health treatment team
- Advocacy—helping participants know what questions to ask and what to expect from treatment
- Information packets, articles, and evidence-based screening tools available to participants and practitioners

The outpatient portion of our Care Advocacy Program includes targeted workflows that ensure treatment is evidence-based. Condition-specific interventions are based upon literature findings, research, and population studies/data mining led by Clinical and Medical Operations leaders.

Facility-Based Treatment

The CIGNA approach to inpatient and other higher levels of treatment follows a similar targeted process, where adding advocacy and evidence-based interventions reinforce the importance of treatment goals and aftercare planning. As part of our Care Advocacy model, CIGNA clinical teams emphasize case management and member engagement, and facilitate practitioners' use of evidence-based practices to reduce or mitigate the need for readmission.

Intensive Case Management Program (ICM)

High-risk cases, as identified by inpatient care managers and a treatment model based on Six Sigma methodology, are referred to our Intensive Case Management Program (ICM).

ICM is a free, voluntary, and confidential service to participants who meet the selection criteria. Participants are invited to participate in the program via a direct telephone call from a Care Manager and can opt out, if desired.

The ICM Care Manager maintains regular telephonic contact with the participant and treating practitioners and assists the participant in identifying community or other resources that may be helpful in the treatment process.



Identifying the CIGNA Participant

Establishing participant eligibility for benefits prior to initiating treatment is essential to ensure claim payment. Participants are not required to obtain prior benefit authorization for routine outpatient care, including diagnostic or initial treatment sessions. Participants can visit the online Provider Directory at www.cignabehavioral.com to search for practitioners or can contact us through the mental health and substance abuse telephone number on their medical identification card. However, coverage for any higher level of care must be preauthorized. Practitioners are responsible for obtaining prior authorization for non-routine outpatient care as well as for all higher levels of care. The practitioner may not bill the participant for care for which prior authorization was not obtained, beyond applicable coinsurance/copayment and/or deductible.

Not verifying eligibility and benefit coverage can result in an Administrative Denial, whereby the practitioner must hold the participant financially harmless if the practitioner was aware of or failed to determine the participant's coverage. If a participant does not have a health care identification card, ask the participant for the information below. Then call CIGNA or go online to www.cignabehavioral.com to verify eligibility and benefits for the participant.

<i>Participant Information</i>	Participant Name
	Zip Code
	Date of Birth
	Subscriber ID #

<i>Plan Subscriber Information</i>	Name
	Participant Number
	Subscriber ID #
	Date of Birth
	Zip Code

Participants enrolled in PPO, OAP, and HMO plans may select a practitioner from a network Provider Directory and are not required to secure prior benefit authorization from CIGNA for routine outpatient services. Preauthorization of coverage and Care Management of inpatient, partial, residential and IOP services for PPO, OAP, and HMO participants *are still required* and must be obtained by the practitioner. Benefits, coinsurance, claim information, and the claims filing address are prominently listed on the participant card.

A practitioner contracted with CIGNA Behavioral must treat all CIGNA participants equally, and must behave as contracted, regardless of service location. You may not require that CIGNA participants sign self-pay agreements prior to providing covered services to them, unless you specifically set forth in detail to the participant and the participant agrees to pay for those specified behavioral care services in writing prior to the delivery of those behavioral care services. Nor may you charge CIGNA participants out-of-network rates. Please refer to your CIGNA Behavioral Participating Provider Agreement for additional information.

Scheduling Appointments

CIGNA has adopted the access standards of the National Committee for Quality Assurance (NCQA), and our appointment access standards now include office wait



times. In addition, participants should be seen within the timeframes listed below based on the severity of their clinical presentation:

<i>Office Wait Time</i>	15 minutes or less
<i>Routine</i>	Within 10 working days
<i>Urgent</i>	As soon as possible but not to exceed 48 hours
<i>Non-Life-Threatening Emergency</i>	As soon as possible but not to exceed 6 hours
<i>Life-Threatening Emergency</i>	Seen immediately
<i>EAP Standard</i>	Within 2 business days
<i>Discharge From Inpatient Care</i>	Within 7 business days

Practitioners are asked to make every effort to ensure compliance by seeing participants within these access standard timeframes. Practitioners who are unable to schedule a participant visit within the access standard timeframes should immediately refer the participant to the online practitioner directory or contact CIGNA through the mental health and substance abuse telephone number on their card for alternative referral.

It is expected that network practitioners have the capability of 24-hour access for participants in crisis and that answering machine greetings contain clear instructions for accessing care in the event of a crisis. General referrals to emergency room settings for all access standards other than non-life threatening and life-threatening emergencies are not considered to be evidence of appropriate crisis coverage.

Care Management Process

Outpatient Care

Participants are not required to obtain prior benefit authorization for routine outpatient care services. Routine outpatient services should include an evaluation for individual, couple, family and/or group therapy, plus a medication evaluation. When participants access providers directly, it is important to ensure benefit coverage and to verify eligibility prior to administering services to participants in plans managed by CIGNA, since practitioners are contractually prohibited from billing participants. The participant's health care identification card lists the appropriate CIGNA telephone number (*Customer Service* at 800.926.2273 can provide information in the event of uncertainty regarding the appropriate number to call for benefit eligibility, or go online to www.cignabehavioral.com).

CIGNA incorporates principles of utilization review and case coordination to facilitate positive treatment outcomes through targeted clinical intervention. Through automated, systematic review of claims, outpatient services are now reviewed using data-driven, clinical algorithms to ensure that care authorized in this way meets standards. Should submitted claims suggest care might require advocacy for adjunct treatment alternatives or interventions, we will contact the practitioner for clinical and/or administrative information so that we may review for continued benefit authorization. When this happens, CIGNA will contact the practitioner to request that they schedule a conversation to discuss the requested information. If they fail to respond to the outreach request, future claims may be at risk for non-payment until the requested information has been received and reviewed by CIGNA.

Practitioners are contractually prohibited from billing participants for non-authorized care.



As participant populations change, we adjust our focus based on acuity and complexity (as well as quality management activities which identify opportunities to improve clinical outcomes or quality of care for our members). Our clinical team utilizes system auto-notification to identify and immediately follow up with identified practitioners and/or participants. We focus on specific clinical categories, using years of data as well as common, evidence-based treatment outcomes to determine appropriate interventions. The clinical Care Management staff is trained to assess disease states and to coordinate care between the participants' employee assistance program, disability management vendor, and medical plan. We work to focus on the

whole picture so that we may have the greatest positive impact on the clinical outcome ensuring, through utilization management activities, that continued authorization is based on the appropriateness of care provided.

To understand our Care Management process and philosophy, it is important to recognize the intrinsic role of the Triage Clinicians, Care Coordinators, and Personal Advocates.

Triage

CIGNA believes that any triage assessment must, at a very minimum, include an evaluation of risk and lethality as well as the possible use and/or abuse of alcohol and other substances, including prescribed medications. The triage function focuses on interventions that will address the immediate crisis. CIGNA maintains a specialized focus on triage at each care center location.

Facility-Based Treatment

Requests for benefit authorization for inpatient or other levels of facility-based treatment are considered within a participant's available benefit coverage and in the context of CIGNA's *Level of Care Guidelines*. Preauthorization of coverage by the practitioner is required for all facility-based services. CIGNA's clinical staff is available 24 hours per day, 7 days per week to review and authorize coverage. If it is determined the requested level of care meets criteria, CIGNA will arrange admission to a participating facility and specify the participating physician to treat the participant.

The Care Advocacy Program philosophy is to marshal resources and to advocate for participants, with a goal of returning them to the highest possible level of functioning as soon as clinically indicated. Designated Care Management interventions are designed to add value to each case. The Care Manager's ability to manage each case with varying levels of appropriate clinical intensity is one of our greatest strengths.

Emergency Admissions

If the acuity of the participant's condition does not allow for preauthorization of coverage, contact CIGNA as soon as possible. Please be prepared to provide the following information to the CIGNA staff:

- Participant's name, age, and participant identification number.
- History, diagnosis, indications, and nature of the immediate crisis.
- Alternative treatment provided or considered.
- Treatment goals, estimated length of stay, and discharge plans.

If the clinical indicators for hospitalization are unclear based on prudent layperson guidelines or CIGNA's *Level of Care Guidelines*, the staff may request additional



information or consult a Physician Reviewer. If coverage for hospitalization is then authorized, the staff will arrange the admission. A Care Manager will then conduct regular, ongoing reviews with the hospital staff.

Referrals

Occasionally, it may be necessary for a practitioner to refer a participant outside of his or her practice. A practitioner should search the provider directory at www.cignabehavioral.com or contact a CIGNA Care Manager for referral to an appropriate CIGNA participating practitioner.

Medication

Non-prescribing practitioners who believe medication should be considered can search the provider directory at www.cignabehavioral.com or contact a CIGNA Care Manager for referral to an appropriate CIGNA participating practitioner. The practitioner can offer the participant the name and phone number of an appropriate prescriber. The participant may then contact the prescriber for an appointment. When medication is prescribed, health plan participants should have prescriptions filled at an authorized health plan pharmacy.

Testing

Prior authorization of benefit coverage is not required for up to four hours of medically necessary psychological testing (see CIGNA's Level of Care Guidelines), when conducted as a part of outpatient treatment. Additional hours of testing will require prior review and benefit authorization by a CIGNA Care Manager. All neuropsychological testing requires prior benefit authorization. At times, testing is used to clarify questions of diagnosis as they directly relate to treatment. Testing related to custody evaluations, rehabilitation, vocational counseling, or school evaluations is generally not covered.

When coverage for psychological testing is recommended, the referral will be made to an appropriate participating psychologist.

CIGNA's Compensation Promotes Quality of Care and Utilization Management

(New Jersey practitioners, please refer to the Medical Management Program – Provider Guide, Section "New Jersey" for state-specific information.)

CIGNA compensates health care practitioners in a manner intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of medical services. CIGNA reinforces this philosophy through utilization management decisions by its Medical Directors, Physician Advisors, and Care Management staff. CIGNA employees are encouraged to promote appropriate utilization rather than under-utilization of health care services.

The same criterion applies for staff eligible to receive additional payments based on their performance. CIGNA employees and consultants receive no financial incentives or rewards to deny coverage of medically necessary care. CIGNA offers no incentives for UM decision-makers for underutilization of care

Coverage Denials

(California Practitioners: please refer to the Medical Management Program – Provider Guide, Section "California" for Coverage Denial information.)

In all cases when the proposed treatment plan includes services that are determined not to be medically necessary according to CIGNA's [Level of Care Guidelines](#), the



Care Manager will discuss treatment alternatives with the practitioner. If a practitioner agrees to a different level of service than the one requested, CIGNA does not consider this a denial. When mutual agreement is reached regarding an alternative level of care, an authorization will be issued.

When agreement is not reached, an opportunity will be offered for the practitioner to review the requested treatment with a clinical peer. The Care Manager will facilitate this *peer-to-peer review process*. In the event a mutually agreed-upon decision is still not reached, a coverage denial will be issued.

All reviews are conducted in a timely manner consistent with the level of urgency in the participant's clinical presentation and in compliance with state law and accreditation standards. Determinations are communicated in writing to the participant, practitioner, and in instances of hospitalization, the facility.

Appeals of Coverage Denials

For clinical cases under review resulting in an adverse determination (coverage denial) following the peer-to-peer review, a review of the decision is available with a physician not previously involved in the case. This *first level appeal review* is with a CIGNA board certified psychiatrist or doctoral-level psychologist, and may be done on an expedited basis, if the situation is deemed urgent and the participant is still in that level of care, or on a standard basis, where more information such as the medical record or a summary of treatment may be made available.

A *second level appeal review* may be available to the participant, the participant's delegate or practitioner on behalf of the participant, in those instances when the denial is upheld at first level appeal. For health plan participants, the standard appeal, is filed through the health plan's Appeals Committee. For non-health plan participants, the appeal is filed through the CIGNA Central Appeals Unit. It is important to note that Appeals Committees are for the purpose of resolving participant issues. Payment disputes where the participant is held harmless are not eligible for review by the Appeals Committee, unless the practitioner, with a participant's written authorization, requests an appeal on behalf of a participant.

A participant, the participant's delegate, or practitioner on behalf of a participant, who is dissatisfied with the outcome of the Appeals Committee determination, may file an appeal by following the health plan, or in some instances, the state's external appeals process. Many states offer an expedited process if the participant feels the situation is urgent and the participant is still in that level of care. The Care Manager assigned to the case is able to provide information regarding the extent of appeals available.

All levels of appeals are reviewed and determinations made by board certified psychiatrists or board certified PhD-level psychologists. If an appeal subsequently overturns an earlier decision, CIGNA will implement the appeal decision and/or process the authorization or claim for payment of services. Decisions are communicated in writing with all adverse determinations and contain the following information:

- The specific guideline on which the determination is based as well as the page number reference within the [Level of Care Guidelines](#);
- The facts and evidence considered; and
- The clinical rationale for the determination.



Administrative Denial and Appeal

Administrative denials may be issued for a number of reasons, including exhausted benefits, services not covered under the participant's benefit plan, lack of prior benefit authorization for services, and/or benefits exhausted for the contract year. Participants, or practitioners on behalf of participants, are entitled to appeal administrative denials.

First level appeal review of an administrative denial occurs at CIGNA by a Central Appeals Unit Appeals Coordinator. A *second level appeal review* may be made in instances when the administrative denial is upheld upon first level appeal review. The second level appeal review for health plan participants occurs with the health plan's Appeals Unit. CIGNA's Central Appeals Unit handles these reviews for non-health plan business.

Practitioner Concerns Related to Administrative Processes

(New Jersey practitioners, please refer to the Medical Management Program – Provider Guide, Section "New Jersey" for more state-specific information.)

CIGNA has a practitioner concern process separate from the administrative or clinical treatment denial and appeal process discussed immediately above. The purpose of this process is to resolve administrative issues.

For administrative concerns, please contact CIGNA as follows:

- Call Claim Customer Service (800.926.2273) with any claim-related issues. For California Practitioners, please see [Appendix A](#)
- Call the appropriate Regional Care Center for Appeals of Administrative Denials (the telephone number will be in the denial letter).
- Call the appropriate Provider Relations department with any provider agreement or fee schedule-related issues (see [Appendix A](#))

It is the practitioner's responsibility to present supporting documentation to the appropriate CIGNA office. It is CIGNA's responsibility to investigate all issues presented and to respond to the practitioner in a timely manner. Practitioners who are dissatisfied with the resolution of their issue may write to the Director of Health Operations Business Unit, the Regional Care Center Director or the Director of Network Operations, as appropriate to the issue, for a final determination. Practitioners who continue to be dissatisfied may pursue arbitration as outlined in the section entitled *Dispute Resolution Procedure* in the Participating Provider Agreement.

If a participant complains to CIGNA about some aspect of care from a practitioner, the practitioner is required to participate in the internal CIGNA complaint resolution process.

If a participant complains to the provider about an administrative issue, the participant should be directed to call the telephone number listed on the participant's health care identification card. For participants residing in California, please refer to [Appendix A](#).

Practitioner's Responsibility to Transition Participant Care

Upon termination or suspension of the Participating Provider Agreement, CIGNA practitioners are responsible for collaborating in the transition of participant care. The Participating Provider Agreement requires practitioners who terminate to



continue to provide service to participants at the contracted rate until treatment is completed, or the participant has been safely transitioned to another practitioner.

Further, for practitioners who are treating participants under a Preferred Provider Organization arrangement, it is CIGNA's expectation that the practitioner will communicate sufficient advance notice of their termination as necessary to promote transition of care, and that they will apprise the participant of the right to continued treatment with the terminated practitioner for up to 90 days post-termination.

In the event of suspension, additional referrals to the practitioner are halted and, depending on the reason for suspension, CIGNA may reassign the practitioner's current participants.

In those states where there are laws regulating the appeal process, the state law supersedes this procedure.