Cigna Payer Solutions

UTILIZATION MANAGEMENT AT A GLANCE

Features. Specifications. Requirements.

This at-a-glance reference tool provides the features, specifications and requirements to deliver the Cigna Utilization Management program to your clients. This document is intended to provide current information but does not supersede contractual obligations and other detailed plan documents or contracts.

Product description

The Cigna Utilization Management program is part of Cigna Payer Solutions' medical management offerings. It can help lower costs and help members avoid unnecessary procedures.

- We make it easier for members enrolled in a Cigna health plan by educating health care professionals in the Cigna network responsible for arranging care and following precertification requirements.
- Our program is Utilization Review Accreditation Commission (URAC) accredited.
- Focuses on facilitating medically appropriate care.

Key features and benefits

Inpatient/outpatient precertification

- Precertification is the process of determining in advance whether a procedure, treatment or service is medically necessary. This helps members to get the right care in the right setting – saving them from costly and unnecessary services.
- Cigna looks for ways to save members money by reviewing inpatient and outpatient services.
- Cigna can help to lower out-of-pocket costs by recommending one of our preferred facilities, transitioning inpatient care to outpatient treatment, or helping to identify treatments or procedures that may be avoidable or unnecessary.
- Inpatient services include procedures, treatments and services received in a hospital or related facility that require an overnight stay.

Concurrent review (inpatient case management)

- Review inpatient stay to encourage appropriate care.
- Work with an individual during his or her hospital stay to help ensure the right care and services are in place for a strong recovery process following discharge.

Discharge planning

- Focuses on identifying and removing any barriers to a smooth, safe and timely discharge to home or to a less intense inpatient setting.
- Helps ensure that individuals can quickly and safely transition to home or a lower level of care without unnecessary delay.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company.

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PRODUCT SNAPSHOT	
Quoting requirements	Must be included with the medical network Services not sold as a stand-alone product
Pricing	Network access fee includes utilization management (UM)
Billing	Billed with network product
Minimum group size	25 subscribers Groups with fewer than 25 subscribers may be aggregated by Payer to a group greater than or equal to 25
PRODUCT FEATURES	
Product components	• Inpatient precertification • Concurrent review (inpatient case management) • Assistance with discharge planning • Outpatient precertification • Retrospective reviews • Medical necessity member appeals
Precertification	• Inpatient/Outpatient precertification is only performed for available procedures listed • Precertification can only be performed by Cigna • Medical necessity reviews are performed within 15 days of receipt of info necessary to make determination • Precertification for Chiropractic and Physical Therapy/Occupational Therapy (PT/OT) is defined as Medical Necessity Review (MNR) after the initial 5 visits and is only available for select geographies performed by participating providers in the American Specialty Health (ASH) network
Inpatient precertification	Precertification for inpatient services is a required component under Cigna's Utilization Management program. Inpatient services include procedures, treatments and services received in a hospital or other facility that require an overnight stay which are reviewed prior to service to ensure medical necessity. • Acute care • Routine and high-risk maternity • Long-term acute care • Skilled nursing facility • Rehabilitation • Detox • Inpatient Mental Health (MH) & Substance Abuse (SA) hospital • Inpatient MH & SA residential *Services will be performed in accordance with state and federal requirements. Urgent/emergency admissions are reviewed post admission.* Observation level of care for stays less than 24 hours are not reviewed for medical necessity. Observation level of care can be approved for services over 24 hours, not to exceed 48 hours. Any stay lasting over 48 hours is considered inpatient acute care.

PRODUCT FEATURES (CONTINUED)

Outpatient precertification

Payer can opt into categories of available services, listed at the group level with the exception of transplant which is a required opt-in. If no categories are chosen, the default will be that no outpatient precertification will be performed. However, should no categories be chosen, the benefit plan must also reflect that no outpatient precertification is required by the plan.

The following service categories are available for outpatient precertification:

CATEGORY	DESCRIPTION
Chiropractic	Enhanced Medical Necessity Review (MNR) after the initial 5 visits for participating ancillary network providers. Limited to states and geographic areas where ancillary network providers are available, and for services performed by those participating providers.
Cochlear implants	Select device implants and replacements Examples: Osseointegrated, cochlear, or auditory brain stem implant
Diagnostic radiology	High-tech radiology service done in outpatient or ambulatory setting Examples: CT scans, MRI/MRA, myocardial perfusion imaging, PET scans and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms • Includes the Informed Choice program, from eviCore healthcare (formerly CareCore | MedSolutions) which encourages use of in-network testing locations for members undergoing an MRI, CT or PET scans
Durable medical equipment	Durable medical equipment with potential to not be medically necessary (possible convenience items) Examples: Seat lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices
Erectile dysfunction	Inflatable and non inflatable prosthesis surgeries and procedures including removal or replacement Examples: Penile implants (does not include erectile dysfunction drugs)
Gastric bypass	Surgery for weight reduction Examples: Gastrectomy, gastric restrictive procedures, lap sleeve
Home health care *Recommended for the management of high-cost specialty drugs*	Category designed for clinician billing for home infusion therapy procedures. (See home infusion therapy) Examples: Registered nurse, licensed practical nurse or aid in the home
Home infusion therapy *Recommended for the management of high-cost specialty drugs*	Intravenous, enteral and parenteral services Examples: Home hydration, total parenteral nutrition (TPN), pain management
Injectable medications *Recommended for the management of high-cost specialty drugs*	Select expensive drugs given intravenously or by injection Examples: Immune globulin, drugs for factor deficiencies, interferon, Rituxan, some chemotherapeutic agents
Oral pharynx procedures	Inpatient, invasive procedures for treatment of snoring or obstructive sleep apnea Examples: Uvulectomy, LAUP procedures

PRODUCT FEATURES (CONTINUED)		
	Orthotics and prosthetics	Devices with potential to not be medically necessary Examples: Helmets, extremity prosthetic additions, electric prosthetic joints, facial prosthesis provided by nonphysician, voice amplifiers
	Outpatient procedures (not otherwise categorized) *Does not include all outpatient surgeries*	Surgeries and procedures that may not be medically necessary Examples: Facial reconstruction, vein therapy
	Physical Therapy/ Occupational Therapy (PT/OT)	Enhanced Medical Necessity Review (MNR) after the initial 5 visits for participating ancillary network providers. Limited to states and geographic areas where ancillary network providers are available, and for services performed by those participating providers.
	Potential experimental/ investigational/unproven procedure *Recommended for the management of high-cost specialty drugs*	Procedures and surgeries which may be experimental, investigational or for which effectiveness is not proven Example: Keratoplasty, total disc arthroplasty, molecular pathology and gene analysis, air ambulance, private duty nursing (Medical necessity review performed after confirmation that benefit exists)
	Sleep Management Program	Sleep services including diagnostic, sleep therapy and sleep supplies Examples: Obstructive sleep apnea, diagnostic or therapeutic sleep studies
	Speech therapy	Treatment of speech disorders, speech pathology in the home Example: Speech therapy
	Spinal procedures	Surgeries and procedures of the spine Examples: Allograft/osteopromotive material for spine surgery, osteotomy, percutaneous vertebroplasty, arthrodesis, laminectomy, vertebral corpectomy, destruction by neurolytic agent
	Therapeutic radiology	Use of radiology for treatment of tumors Examples: Brachytherapy, proton beam therapy, radiotherapy
	Transplants *Required opt-in with Cigna LifeSOURCE Transplant Network®*	Outpatient transplant evaluation testing Prior authorization for transplant event is done in the outpatient setting Examples: Adult or pediatric, living or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants; preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants; transplant related travel and lodging
	Unlisted procedures	Procedures given miscellaneous identifiers when they cannot be categorized into established codes; many codes end in "99" Examples: Vascular surgery, miscellaneous DME, unclassified drugs/biologics

Note Examples are not inclusive of all services contained within each example and are subject to change without notice. Please provide CPT/HCPC code for review by exception committee if authorization is required.

PRODUCT FEATURES (CONTINUED)	
Outpatient mental health and substance abuse precertification	Precertification is not an available service
Concurrent review (inpatient case management)	Medical team reviews inpatient hospital admissions based on nationally recognized criteria, evidence-based medicine and clinical information. They also monitor appropriateness of care, setting and discharge plans to save costs and ensure quality of care
Discharge planning	Discharge planning begins at the initial notification of admission. When managing an individual in the hospital, our inpatient case managers promote timely and efficient care and proactive planning for discharge
Retrospective reviews	• Review performed by nurses for procedures that were not precertified as required. • Retroactive reviews available up to 365 days after date of service. • Reviews are performed within 30 days from the day clinical information is received.
Medical necessity vs. coverage	• All precertifications will be in accordance with Cigna's medical necessity guidelines, and will be a medical necessity determination only. Cigna will not guarantee benefits coverage. • Health service providers will verify benefits and eligibility with Payer prior to initiating precertification from Cigna. • Payers should send Cigna a current group summary plan description (SPD), so if applicable, care can be directed appropriately. However, Cigna will not determine benefits or guarantee coverage during medical necessity determination.
Precertification approvals	• Nonclinical Cigna intake staff can approve some procedures. • For procedures that require clinical input, intake staff opens the case and sends it to an RN reviewer. RN reviewers may issue an approval, or send complex cases to a medical director for review and approval. • All approvals generate an approval letter to provider, with a copy to the patient.
Precertification denials	• Cigna medical directors are responsible for issuing denials. All denials generate letters to the provider and patient including information about filing an appeal.
Peer-to-peer service	• All physicians, in- or out-of-network, can take advantage of Cigna's peer-to-peer program, by calling a medical director to discuss a case that may have been denied. These discussions are encouraged, as the most common reason for denials is missing clinical information that is critical to reviewing a case. • The Payers' medical directors can also use peer-to-peer services on any cases for which they have questions.
Medical necessity appeals /External reviews	• Cigna to manage all medical necessity appeals related to the denial, or partial denial, of services under Cigna's UM program in accordance with Cigna's standard appeals program and procedures (refer to appeals Policies and Procedures (P&P) for applicable funding type). Client customizations to standard appeals program and procedures, if available, will require Cigna approval, and will result in additional charges. • Cigna to provide members with the right to an independent, third-party review, by an independent Review Organization (IRO). • Payer to manage all claims, benefits and eligibility appeals. Should an appeal involve interpretation of provider contracts or rates, Payer to forward Cigna appeal within four business days.
Coordination of benefit (COB) requirements (Medicare and commercial)	• **Medicare primary individuals:** Not allowed on the plan per Network PPO requirements. Should Cigna determine Medicare has become the primary carrier while on the plan, Cigna will not perform any UM and will notify payer to take member off of PPO plan. • **Medicare secondary:** If Medicare is a secondary payer such as for an active employee, Cigna to perform UM in accordance with its standard policies. • **Commercial COB:** Payer to determine if Cigna is primary, and if so, standard UM processes would apply. If Cigna is not primary, Cigna will not perform UM.

PRODUCT FEATURES (CONTINUED)	
Predetermination	• Cigna does not perform predeterminations. Payers are responsible for verifying benefits and eligibility. • Requests from Payers for "predetermination" are treated as a precertification, where medical necessity will only be reviewed for procedures on the group's precertification list.
Steerage	• Cigna will steer to in-network providers whenever appropriate, but will not require it. Any out-of-network case-level agreements requested will be sent to the Payer to negotiate with health care professional.
Transition of care	• Transition of care (TOC) benefits are administered by the Payer. TOC is a benefit determination, which if made available by the payer, offers members a benefit where out-of-network health care professionals are paid at an in-network benefit level for a specified period of time (grace period), while a member transitions care to an in network health care professional. • Cigna will administer UM in accordance with par/non par status of a health care professional on the date of service. Inquiries about TOC benefits will be referred back to the Payer.
Integration with external vendors	• Integration of UM with external vendor programs (case management, disease management, stop loss, etc.) will be administered by the Payer. Cigna will work directly with the Payer if case-specific information is needed.
Medical opinions	• Medical opinions on standard of care can be given through Cigna's Physician Consultation Services product (PCS). Hourly fee applies. • Medical opinions on standard of care will not be rendered by RNs.
Access to approval/denial information	• Daily authorization files are sent to the Payer showing approvals and denials issued. • Some exceptions may apply regarding authorization data from national ancillary networks.
High-dollar notification	• Cigna will provide proactive notification to the Payer for potential high-dollar claimants via ProviderLink. • Payer should continue to use the Medical Management Reporting Portal (MMRP) and Daily Authorization Extract file to identify potential high-dollar claimants. The Payer should not rely solely on ProviderLink for an inclusive list.
Provider contract requirements	• Cigna to administer UM program in accordance with its administrative policies and procedures according to health care professional contracts. No other entity can perform UM on in-network health care professionals. • Cigna to perform UM functions, including concurrent review criteria for diagnosis related group (DRG) contracts, in accordance with its health care professional agreements.
Transplant	• Perform utilization management services for transplant-related inpatient and outpatient services. • The same team also provides case management services if Case Management is purchased. • Transplants include: hematopoietic stem cell/bone marrow (autologous & allogeneic), heart, lung, liver, kidney, pancreas, dual organ and intestinal/multivisceral transplantation for both adult/pediatric population.
Transplants in progress	• Previous precertification received prior to contracting with Cigna can be transferred for members in the evaluation and candidacy zones.
Transplant precertification – revocation	• Transplant services require precertification. • Authorization for transplant-related services can be revoked on a prospective basis. • No retroactive revocations.

PRODUCT FEATURES (CONTINUED)	
Transplant services *(Defined by care zone)*	**Zone 1 – evaluation** Transplant candidate identification. Includes all diagnostic tests performed on the member and a live donor, if applicable. Begins when the member starts the scheduled evaluation testing/consults. Ends when the member is listed with United Network for Organ Sharing (UNOS) for solid organs or accepted for a bone marrow, stem cell or cord blood transplant. **Zone 2 – candidacy** Solid organ transplant includes: Transplant-related care only for routine surveillance of the recipient to maintain the candidacy status and listing with UNOS. Includes testing needed to determine organ function; includes clinic visits and lab charges. Does not include ongoing maintenance care such as renal dialysis. Bone marrow, stem cell and cord blood cases start after the member has been accepted into the transplant program, and end the day prior to the initiation of mobilization for autologous and the day prior to initiation of the preparative regimen for allogeneic. **Zone 3 – transplant event** Begins the day of admission for the transplant procedure. Ends when the recipient is discharged from the hospital. Autologous bone marrow and stem cell transplant events begin the first day of mobilization and end 45 to 60 days after the date of infusion. Allogeneic bone marrow and stem cell transplant events begin the day of initiation of the preparative regimen and end 60 to 90 days after the date of infusion. All services provided during the Zone 3 time frame are included in the Zone 3 case rate (less contract exclusions). **Zone 4 – post transplant follow-up care** Solid organs, begins the day after discharge from the transplant admission and ends 90 days to one year later. Bone marrow, stem cell, cord blood transplants, begins the day after Zone 3 expires and ends 90 days to one year later.
SERVICE	
Implementation	• New Payer: During the implementation process, medical management processes and standard operating procedures will be reviewed by Cigna for the Payer. • New groups: Cigna will work with Payer to produce a group snapshot for each new group during the group implementation process. The snapshot will indicate services that require precertification.
Eligibility	• Eligibility data used for network will also be used for the UM product; Payer is responsible for sending accurate compliance information on eligibility file that would be needed to comply with state and federal regulations.
Customer service	• Precertification staff is available Monday–Friday 8:00 am–7:00 pm (CT). Calls should be received at the Payer first to verify benefits and eligibility and then transferred to the Cigna Payer Solutions call center. • Should a call come directly to the Cigna Customer Service Center after normal business hours, callers can select an emergency option, and their call will be routed to a live Cigna representative where their information will be documented and forwarded to the medical management team to be reviewed during the next business day.
Reporting	• Payers can access the Medical Management Reporting Portal (MMRP) to view the following reports: Closed and Open Cases, Shock Loss Trigger Report, Open and Closed Inpatient Events, Open and Closed Outpatient Events, Readmissions, Confinements Greater than Seven Days, and CareEnhance Clinical Management Software (CCMS) Documented Savings • Print and view-only access to our CareEnhance Clinical Management Software (CCMS) is also available. Note: Installation fees may apply. This desktop application allows access to view our clinical system in real time. Information includes member level detailed clinical notes, status of requested authorizations, and copies of approval and denial letters sent to members.

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