



THE GLOVES ARE OFF:

The Aetna and CIGNA settlements: Part II

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During the 1990s, a number of lawsuits were filed across the country on behalf of physicians against managed care organizations. These lawsuits alleged that the health plans conducted improper contracting and payment practices. In October 2000, the lawsuits were consolidated and transferred to the U.S. federal court in Florida as a class action lawsuit. Two of the defendants, Aetna and CIGNA, agreed to settlements rather than continue the litigation. The other managed care companies that are defendants in this litigation have not agreed to settlements at this time and the lawsuit against those organizations continues to move toward a trial, which is currently scheduled to begin in March 2005.

The first article in this two-part series provided information about the Aetna settlement (July 2004, page 12). This second article continues with a discussion of physician compensation available under the CIGNA settlement, the appeals process, and the enforcement procedures established to ensure that Aetna and CIGNA comply with the provisions of the settlements in the future.

The final order for the CIGNA settlement was issued in April 2004. The elements of prospective relief provided by the settlement are similar to the

disclosure and business practice changes established in the Aetna settlement. It establishes a Web portal through which CIGNA participating physicians may check patients' eligibility, status of claims, fee schedules, policies, and procedures, as well as any updates and changes to these items. CIGNA is providing \$15 million in funding for The Physicians' Foundation for Health Systems, which is charged with developing health care initiatives for patients and providers. CIGNA has also established a physician advisory committee to advise the company on national health care issues.

Surgeons who are party to the class action should have received CIGNA's formal notice of commencement of claims period that was mailed on July 8, 2004. During the claims period, which begins August 23, 2004, and ends February 18, 2005, class action members may apply for compensation from the funds established by the settlement. *Claims for denials of or reductions in payment that were a result of payment and benefit limitations (such as coordination of benefit rules, violations of preauthorization or referral requirements, limitations cited in capitation agreements, and services excluded from coverage under the CIGNA member's plan) are ineligible for compensation.* Poorman-

Douglas Corporation, the settlement administrator for CIGNA, will handle all compensation claims. Physicians may apply for compensation from either the Category A settlement fund or the claims distribution fund.

Category A settlement fund

All class members may apply for compensation from CIGNA's Category A settlement fund regardless of whether they have submitted any claims to CIGNA HealthCare during the period from August 4, 1990, through September 5, 2003, as long as they have submitted claims for payment during that period to Aetna, Aetna-USHC, Anthem, CIGNA, Coventry Health Care, Health Net, Humana Health Plan, Humana, PacifiCare Health Systems, Prudential Insurance Company of America, United Health Care, United Health Group, or Wellpoint Health Networks.

Physicians who opt to apply to the Category A settlement fund are not expected to produce documentation in order to receive compensation, which will be distributed according to a formula contained in the settlement. They must complete and return a Category A claim form to the settlement administrator. All payments from the Category A settlement fund will be made approximately two weeks after the claims period has ended. Please note that, in lieu of receiving payment, physicians may contribute their share of the settlement fund to The Physicians' Foundation for Health Systems or to a similar entity established by any medical society that signed or joined the settlement.

Claim distribution fund

Surgeons who believe they were specifically denied appropriate payment for services by CIGNA Corporation or its subsidiary entities (CIGNA Healthcare, Connecticut General, Healthsource, Lovelace Health Systems, Ross Loos Hospital) from August 4, 1990, through April 22, 2004, may choose to forgo compensation through the Category A settlement fund and apply to CIGNA's claim distribution fund. A complete list of the CIGNA entities can be found at <http://www.cignaphysicianssettlement.com/entities.htm>. There are three categories of the claim distribution fund: Category One, Category Two, or medi-

cal necessity denial. Requests for payment may be submitted under any or all of the three separate categories.

Category One applies to claims that are defined by a negotiated list of code edits published as part of the settlement.* This option requires a valid proof of claim that the procedures were denied by CIGNA. The code edits for which additional payment is due that may be of most interest to surgeons are:

- Biopsy of skin, subcutaneous tissue and/or mucous membrane that were bundled into destruction of skin lesions (codes 17000-17999 paid; code 11100 not paid).
- Destruction of lesion(s) that were bundled into shaving or excision of epidermal/dermal lesions (codes 11300-14000 paid; code 17000-17004 not paid).
- Chemical cauterization of granulation tissue that was bundled into collection of venous blood by venipuncture (code 36415 paid; code 17250 not paid).
- Upper gastrointestinal endoscopy with biopsy that was bundled into upper gastrointestinal endoscopy with insertion of guidewire and dilation or balloon dilation of esophagus (codes 43248-43249 paid; code 43239 not paid).
- Sigmoidoscopy with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery that was bundled into sigmoidoscopy by snare technique (code 45385 paid; code 45384 unpaid).

A complete list of Category One code edits can be downloaded in Adobe Acrobat (.pdf) format at <http://www.cignaphysicianssettlement.com/categoryone.htm>.

Category Two compensation applies if the payment denial or reduction was a result of the application of CIGNA's proprietary coding and bundling edits that are unspecified as eligible for Category One compensation. CIGNA has provided the settlement administrator with a facilitation list that identifies provider claims for which payment was denied or reduced because code edits were applied, modifiers and add-on codes were not recognized, or multiple procedure rules were applied incorrectly. To determine whether to pursue payment

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through the Category Two list, physicians should request a facilitation list for their claims from the settlement administrator.

To request compensation for claims that were improperly denied by CIGNA as not medically necessary or as experimental or investigational, physicians should apply to the medical necessity denial compensation fund.

Applying for compensation

Physicians requesting compensation from the claim distribution fund must submit the appropriate proof of claim form. (Proof of claim forms should not be submitted until the claims period begins.) CIGNA advises claimants that they should use *only* the “official version” of the proof of claim form (bar-coded) when submitting request for payment. A single proof of claim form may be used for more than one compensation request. A separate cover sheet and the required documentation for each request must be attached to the form. Copies of the official forms (including the cover sheets for Category One, Category Two, and medical necessity denial claims) can be found at <http://www.cignaphysicianssettlement.com/documents.htm> or requested from the settlement administrator.

The required documentation for Category Two and medical necessity denial requests consists of a copy of the original HCFA-1500 form *or* the relevant CIGNA remittance form. (If those forms are unavailable, printouts of accounts receivable or paid account records will be accepted.) Claimants also must provide clinical information relevant to each claim. For denial of claims for surgical procedures, claimants must provide clinical notes and operative notes. To view the list of documentation requirements for other CPT codes, please go to <http://www.cignaphysicianssettlement.com/clinicalDocumentation.htm>. Two exceptions have been made to the clinical information requirement. No clinical documentation is required if: (1) the request for payment is for a claim where CIGNA HealthCare failed to recognize modifiers 50, RT, LT, FA-F9, or TA-T9, and denied payment for one or more CPT codes as duplicative of other CPT codes reported; or (2) CIGNA HealthCare incorrectly processed one or more modifier 51 exempt CPT codes and/or add-on CPT codes due to CIGNA

edit software when those codes were exempt from multiple procedure reduction.

Some practice management software maintains electronic records that contain information that would be included on a HCFA-1500 form and can generate a print image file. Practices that use this software can submit claims documentation electronically to a Web portal that is being operated by Infinedi LLC, which will create HCFA-1500 forms containing the claims information. If supporting documentation is required for a claim and it is possible to create a .pdf or .tif file, that documentation can be uploaded to the Infinedi site, and the complete file will be transmitted to CIGNA by Infinedi. Proof of claim forms must be completed and signed prior to electronic submission. For more information about electronic submission of compensation claims, please go to www.cignaeclaims.com.

If CIGNA denies compensation for a Category Two or medical necessity compensation request based on its determination that the original decision to reduce or deny payment was appropriate, that request will automatically be forwarded to an independent review entity (IRE) to determine the appropriateness of the decision.

The settlement administrator for any of the items cited in this article can be contacted by e-mail at <http://www.cignaphysicianssettlement.com/contact.htm>, by phone at 1-877/683-9363, or by mail at CIGNA Physicians Settlement, Settlement Administrator, P.O. Box 3170, Portland, OR 97208-3170.

The enforcement process

Both Aetna and CIGNA have revised their appeals processes as a result of the settlements. If physicians believe that any claims submitted after the deadlines for compensation under the settlements have been improperly denied or paid, they will have to first appeal those disputes with Aetna or CIGNA. The CIGNA agreement allows for two levels of internal appeal. If the determination of initial appeal is unsatisfactory, physicians may request that the claim be reviewed by a member of the same specialty as the performing physician. The review of and response to claim disputes must be completed within 45 days. If the response to an appeal is also unsatisfactory, independent

review mechanisms have been created to offer physicians additional avenues for reconsideration and to ensure that Aetna and CIGNA are complying with the settlements. They are as follows:

- *Billing dispute resolution process.* The IRE process may be used for retained claims (defined below), coding, and other payment rule disputes, including disputes over burdensome record requests, after completion of the Aetna or CIGNA internal review process.

For CIGNA, retained claims are ones that either were filed but not adjudicated (including any internal appeals) as of April 22, 2004, or claims that have not yet been filed but for which the filing period has not expired. The settlement agreement stipulates that claims that involve the application of CIGNA's coding and payment rules and methodologies that were finally adjudicated between March 24 and April 21, 2004, are also considered retained claims. Detailed information on the submission of retained claims to the billing dispute external review process can be found at www.CIGNAforHCP.com.

For Aetna, billing disputes for \$500.01 or more may be submitted to the IRE within 90 days of an Aetna appeal decision. (Physicians may request that the IRE aggregate similar claims for up to one year to reach the required \$500.01.) The filing fee for the service is a minimum of \$50 and an additional 5 percent of amounts in dispute over \$1,000, capped at 50 percent of the IRE's charge for the review. In most cases, the IRE will issue its decision within 60 days of the date the appeal is filed.

- *Medical necessity dispute resolution process.* If a physician receives a denial based on Aetna's or CIGNA's determination that the services were not medically necessary or were experimental or investigational, the decision may be appealed to the appointed external review organization. (If a patient has filed an Employee Retirement Income Security Act of 1974 lawsuit in a federal court, this review is not an option.) For Aetna, this process should be available this month, and there is a filing fee of \$50 or up to \$250 for cases requiring prior authorization.

The date for the initiation of CIGNA's process and any fees associated with filing of billing dispute or medical necessity dispute claims have not been announced.

These processes are optional with Aetna but

binding if used. Physicians are free to pursue remedies independent of the established processes, such as resolution of a dispute by arbitration. The Aetna settlement establishes a cap of \$1,000 for arbitration fees for solo and small practices.

- *Compliance dispute resolution process.* The settlements provide a mechanism whereby non-compliance by Aetna or CIGNA to the obligations set forth in the agreements may be reported. This process would most likely be used if a pattern of behavior was identified. Compliance disputes may be filed by any class member who has been adversely affected by a breach of the settlement agreements or by a signatory medical society on behalf of a physician or a practice. Any compliance disputes will be reviewed by an appointed compliance dispute officer. If the compliance dispute officer finds that noncompliance has occurred, the offending party will have 30 days to resolve the problem. Failure to remedy the noncompliance could result in legal intervention to force compliance. All Aetna and CIGNA compliance disputes will be handled by the compliance dispute facilitator.

As a reminder, the state and local medical societies and associations that are signatories to the settlement agreements may represent physician members who have future disagreements with Aetna and CIGNA through the compliance dispute process for violations of the terms of the settlement as well as violations of state law relating to such terms. Physicians who choose to opt out of the class action may not use the compliance dispute process. Surgeons should contact the appropriate medical or specialty society in their area for more specific information about the effects of the settlement on their practices. □

The information contained in this article is based on documents provided by the American Medical Association in March 2004 and supplemented with information contained on the Aetna provider Web site, the CIGNA Healthcare physician settlement Web site, the HMO Crisis Web site maintained by the Law Offices of Archie Lamb, and the HMO settlements Web site maintained by Milberg Weiss Bershad & Schulman LLP. The Law Offices of Archie Lamb and Milberg Weiss Bershad & Schulman LLP represented physicians in the Aetna and CIGNA health care litigation.