# PAYMENT RULE COMPARISON (January 15, 2004)

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| **Fee Schedule Disclosure** | Public Health Law section 4406-c(5-a) provides that contracts entered into between a plan and a health care provider must include terms which prescribe:<br>"(a) the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;<br>(b) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;<br>(c) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the provider can access a summary of such calculations and adjustments;<br>(d) the process to be employed to resolve disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed …" | By December 31, 2004, on the Provider Website, on a confidential basis, each Participating Physician will be able to view the complete fee schedule applicable to such Participating Physician pursuant to that Participating Physician's direct written agreement with Aetna. Each such fee schedule shall state the dollar amount allowable for each CPT® code for Covered Services rendered by such Participating Physician's office. Until implementation of the initiative described above, Aetna, upon written request from a Participating Physician or Physician Group that, in each case, has entered into a written contract directly with Aetna, will provide the fee schedule for up to fifty (50) CPT® codes, as specified by such Participating Physician. Aetna shall be obligated to honor only one such request made annually by such Participating Physician. Aetna will attempt to include provisions in its agreements with Delegated Entities that require comparable disclosure. §7.3 | A Class Member shall be entitled to use a specified electronic mail address to make reasonable requests for applicable fee schedule amounts for all CPT® or other billing codes related to a Class Member's practice. CIGNA HealthCare shall use its best efforts to prepare and provide responsive information to Class Members' electronic mail inquiries under this Section within ten (10) days of receiving such inquiries. There will be no charge for such inquiries, regardless of the number of such inquiries made. CIGNA HealthCare shall make this procedure available to Participating Physicians and other Physicians who are considering becoming Participating Physicians. §7.3<br>If CIGNA HealthCare uses databases licensed from one or more third parties in order to determine "reasonable and customary" billed charges in the medical community, those databases shall be identified. §7.2(a)(2)(l). | None. |

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| | The New York State Department of Health has issued a letter to MSSNY which expressed an opinion in agreement with MSSNY that Public Health Law section 4406-c(5-a) requires the health plan to disclose either information sufficient to calculate a specific fee or the specific fee itself. | | | |
| **Payment of Vaccines and Injectables and Administration** | | Company agrees to pay a fee (per the applicable fee schedule for Participating Physicians and a reasonable fee for Non-Participating Physicians) for the administration of vaccines and | CIGNA HealthCare agrees to pay a fee (per the applicable fee schedule for a Participating Physician and a reasonable fee for Non-Participating Physicians) for the administration of | |
| | | injectables in addition to paying for such vaccines and injectables. Company agrees to pay Participating Physicians for the cost of injectables and vaccines at the rate set forth in the applicable fee schedule in each market, as in effect from time to time. With respect to capitated Participating Primary Care Physicians, Company agrees to continue paying fees in addition to the capitation payments for primary care services administered pursuant to the schedules recommended by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices, as applicable; provided that if the primary care Participating Physician so | vaccines and injectables in addition to paying for such vaccines and injectables. CIGNA HealthCare agrees to pay Participating Physicians for the cost of injectables and vaccines at the rate set forth in the applicable fee schedule in each market, as in effect from time to time. With respect to capitated primary care Participating Physicians, CIGNA HealthCare agrees to continue to pay fees (in addition to contractually agreed-upon capitation payments) for vaccines administered pursuant to the schedules recommended by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices, as applicable; provided | |

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| | | requests, Company may include such fees within the scope of capitated services. As of the effective date of such recommendation, Company shall pay for vaccines newly recommended by the institutions identified above. Other than as specified in the preceding sentence with respect to vaccines, if a Physician Specialty Society recommends a new technology or treatment or a new use for an established technology or treatment as an appropriate standard of care, Company shall evaluate such recommendation and issue a Coverage Policy Bulletin or the equivalent not | that if the primary care Participating Physician so requests, CIGNA HealthCare may include such fees within the scope of capitated services. As of the effective date of such recommendation, CIGNA HealthCare shall pay for vaccines newly recommended by the institutions identified above. Other than as specified in the preceding sentence with respect to vaccines, if a Physician Specialty Society recommends a new technology or treatment or a new use for an established technology or treatment as an appropriate standard of care, CIGNA HealthCare shall | |
| | | later than 120 days after Company learns of such Physician Specialty Society recommendation. Company agrees to list in the Certification to be filed annually and at the end of the Effective Period the dates on which such updates are completed and to include in such Certification any written policies and procedures it has developed regarding payments for the administration of vaccines and injectables. §7.14(b). | evaluate such recommendation and issue a coverage statement not later than one hundred twenty (120) days after CIGNA HealthCare learns of such Physician Specialty Society recommendation. CIGNA HealthCare agrees to list in the Certification to be filed annually and at the end of the Effective Period the dates on which such updates are completed and to include in such Certification any written policies and procedures it has developed regarding payments for the administration of vaccines and injectables. §7.14(b). | |
| **Payment Rule Disclosure Consistent Rules** | | By December 31, 2004, Aetna's automated "bundling" and other claims payment rules will be consistent in all material respects across ongoing claims systems | CIGNA's automated "bundling" and other claims payment rules must be consistent in all material respects across its ongoing claims systems and products. | None. |

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| **Across Products** | | and products. §7.8(a). | §7.8(a). | |
| **Web-based Adjudication Tool** | | By December 31, 2003 or as soon thereafter as practicable Aetna will make available a web-based pre-adjudication tool incorporating the McKesson Corporation software product known as "ClaimCheck®" (or other equivalent software then used by Aetna), as customized by Aetna. Such software shall produce results consistent with the standards set forth below. Aetna agrees to design such tool so that it may provide information to Participating Physicians regarding the manner in which Aetna's claim system | If a software vendor makes commercially available a web-based pre-adjudication tool that would allow Participating Physicians to obtain information regarding the manner in which CIGNA HealthCare's claims systems adjudicate claims for specific CPT® Codes or combinations of such Codes, consistent with the provisions of this Agreement, CIGNA HealthCare shall make such tool available on its Website as soon as practical after it becomes available on commercially reasonable terms. §7.8(b). | None. |
| | | adjudicates invoices for specific CPT® codes or combinations of such codes. §7.8(b). | | |
| **Disclosure of Payment Rules** | See summary of Public Health Law § 4406-c(5-a), provided above. | By December 31, 2003, or as soon thereafter as practicable, Aetna will disclose on its Website its payment rule or approach in each area in which CMS has promulgated a definitive rule or approach that is relevant to payment of Physicians for Covered Services. §7.8(c).<br>By May 6, 2004, Aetna will disclose on its Website a list of each Aetna-specific customization to the standard claims editing software product then used by Aetna; provided that no such customization shall be inconsistent with the undertakings set forth in this | The computer claims processing software or programs used by CIGNA HealthCare to review the relationships among billing codes (e.g., ClaimCheck® shall be identified by name and version, including any software used to audit the relationship between CPT® or HCPS Level II Codes, or other billing codes, and diagnosis codes. §7.2(b).<br>CIGNA HealthCare shall use its best efforts to describe with particularity any single Claim Coding and Bundling Edit that it reasonably judges, based on its experience with submitted claims, will cause, on the initial | None. |

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| | | Agreement. §7.8(c)(i)<br>By May 6, 2004, Aetna will disclose on its Website any circumstances as to which it has determined that particular services or procedures, relative to modifiers 25 and 59, are not appropriately reported together with those modifiers; provided that no such determination shall be inconsistent with the undertakings set forth in this Agreement. §7.8(c)(iii). | review of submitted claims, the denial of or reduction in payment for a CPT® Code or HCPCS Level II Code more than five hundred (500) times per year. To the extent CIGNA HealthCare intends, following Final Approval of this Agreement, to apply any Claim Coding and Bundling Edits that are identified for Category One Compensation in this Agreement, those Claim Coding and Bundling Edits shall be identified. §7.2(f).<br>CIGNA HealthCare's policies regarding the reimbursement of supplies and materials utilized in the provision of Covered Services by Class Members, including those instances where | |
| | | | the submission of Clinical Information may be required in order for Class Members to obtain payment of the claim as submitted, shall be described. §7.2(g).Consistent with this Agreement, CIGNA HealthCare's policies and procedures for reducing the indicated payments for the second and subsequent procedures performed on the same patient on the same date of service shall be described. §7.2(h). | |
| **Fairer Payment Rules Payment Rules Consistent with CPT and Medical** | | See below. | See below. | None. |

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| **Profession Standards** | | | | |
| **Claims Editing Software Consistent with Rules** | | Aetna's claim-editing software will produce editing results consistent with the standards set forth below.<br>If any change to CPT® affects Aetna's obligations hereunder, Aetna will promptly develop plans to cause its payments to Physicians to be consistent with this change. §97.8(a). & §7.20(b)(ix). | CIGNA HealthCare shall modify its claim processing and claim payment policies as follows and will insure that its automated claims handling will be consistent with the requirements of this Agreement. §7.20. | None. |
| **No Automatic Downcoding E&M Codes** | | Aetna shall not automatically reduce the code level of evaluation and management codes billed for Covered Services ("**Down-coding**").<br>Notwithstanding the foregoing sentence, Aetna shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by selected Physicians or Physician Groups or Physician Organizations) based on a review of the information in the written medical record at the time the service was rendered for particular claims, a review of information derived from Aetna's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools | CIGNA HealthCare shall not automatically reduce the code level of CPT® Evaluation and Management Codes billed for Covered Services.<br>Notwithstanding the foregoing sentence, CIGNA HealthCare shall continue to have the right to deny or adjust such claims for Covered Services on other bases and shall have the right to reduce the code level for selected claims for Covered Services (or claims for Covered Services submitted by a selected Class Member) based on a review of Clinical Information at the time the service was rendered for particular claims, a review of information derived from CIGNA HealthCare's fraud and abuse detection programs that creates a reasonable belief of fraudulent, abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate coding of | None. |

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| | | that reasonably identify inappropriate coding of evaluation and management services; provided that the decision to reduce is based at least in part on a review of the clinical record. §7.19. | Evaluation and Management services; provided that the decision to reduce is based at least in part on a review of the Clinical Information. §7.19. | |
| **Well-woman Code** | | Prohibited by HIPAA. | After October 14, 2003, CIGNA HealthCare shall process claims for obstetrical and gynecological examinations using standard CPT® Codes denoting Evaluation and Management services, eliminating use of the CIGNA HealthCare "well woman" code (*i.e.*, code 90769). §7.20(b). | None. |
| **Add On and Modifier 51 Exempt** | | No modifier 51-exempt codes shall be subject to Multiple Procedure Logic. §7.20(b)(i). "Add-on" codes, as designated by CPT®, shall be recognized and eligible for payment as separate codes and shall not be subject to Multiple Procedure Logic. §7.20(b)(ii). | CIGNA HealthCare will process and separately reimburse add-on billing codes and modifier 51 exempt billing codes without reducing payment under CIGNA HealthCare's Multiple Procedure Logic; provided that the add-on codes are billed with a proper primary procedure code according to the guidelines and protocols set forth in CPT®. §7.20(d). | None. |
| **Modifier 25** | | If a bill contains a CPT® code for performance of an evaluation and management CPT® code appended with a modifier 25 and a CPT code for performance of a non-evaluation and management service procedure code, both codes shall be recognized and eligible for payment, unless the clinical information indicates that use of the modifier 25 was | CIGNA HealthCare shall not require Class Members to submit Clinical Information of their patient encounters in order to receive payment for both surgical procedures and CPT® Evaluation and Management services for the same patient on the same date of service. CIGNA HealthCare shall pay for both CPT® Evaluation and | None. |

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| | | inappropriate or Aetna has disclosed that such services are not appropriately reported together. §7.20(b)(iii). | Management Codes and surgical codes or other procedure codes when submitted for the same patient on the same date of service with appropriate modifiers (*e.g.*, modifiers 25 and 57), unless a Claim Coding and Bundling Edit (which edit will be disclosed on the Website and shall be consistent with this section 7.20) precludes payment of the specific combination of billing codes involved. Additionally, CIGNA HealthCare will remove from its claim review and payment systems those Claim Coding and Bundling Edits that generally deny payment for CPT® Evaluation and Management Codes when submitted with surgical or other procedure codes | |
| | | | for the same patient on the same date of service except for a discrete number of exceptions which will be disclosed on CIGNA HealthCare's Website. Nothing in this Agreement shall prohibit CIGNA HealthCare from requiring use of the appropriate CPT® Code modifiers for Evaluation and Management billing codes (*e.g.*, modifiers 25 and 57) on their original claim forms. Moreover, nothing in this Agreement shall preclude CIGNA HealthCare from requiring Participating Physicians and Non-Participating Physicians (to the extent the audit is limited to claims submitted under an Assignment of Benefits) to submit to an audit | |

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| | | | of their submitted claims (including claims for surgical procedures and Evaluation and Management services on the same date of service), and to produce copies of their Clinical Information in connection with such an audit. §7.20(a). | |
| **Supervision and Interpretation** | | A CPT® Code that includes supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that for each such procedure (e.g., review of x-ray or biopsy analysis) Aetna shall not be required to pay for supervision or interpretation by more than one physician. | A CPT® Code that includes supervision and interpretation shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided, that for each such procedure (*e.g.*, review of x- ray or biopsy analysis), CIGNA HealthCare shall not be required to pay for supervision or interpretation by more than one | None. |
| | | §7.20(b)(iv). | physician; and provided further that, consistent with Section 7.8.(c)of this Agreement, nothing in this Section 7.20(e) shall preclude CIGNA HealthCare from requiring the submission of Clinical Information substantiating that the requirements of the billed CPT® Code have been satisfied. §7.20(e). | |
| **Indented Codes** | | Other than codes specifically identified as modifier 51-exempt or "add-on", a CPT® code that is considered an "indented code" within the CPT® code book shall not be reassigned into another CPT® code unless more than one indented code under the same indentation is also | Other than codes specifically identified as modifier 51-exempt or "add-on," a CPT® Code that is considered an indented code within CPT® shall not be reassigned into the primary (*i.e.*, non-indented) code, from the same CPT® Code series, unless more than one indented code | |

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| | | submitted with respect to the same service, in which case only one such code shall be eligible for payment; provided that for indented code series contemplating that multiple codes in such series properly may be reported and billed concurrently (e.g., cardiac catheterization series), all such codes properly billed shall be recognized and eligible for payment. §7.20(b)(v) | under the same indentation is submitted with respect to the same service, in which event only one such code shall be eligible for payment; provided that for indented code series contemplating that multiple codes in such series properly may be reported and billed concurrently, all such codes properly billed shall be recognized and eligible for payment. §7.20(f). | |
| **Modifier 59** | | A CPT® code appended with a modifier 59 shall be recognized and separately eligible for payment to the extent they designate a distinct or independent procedure performed on the same day by the same Physician, but only to | CPT® Codes submitted with a modifier 59 attached will be recognized and eligible for payment to the extent they designate a distinct or independent procedure performed on the same day by the same Physician, but only to | None. |
| | | the extent that (1) such procedures or services are not normally reported together but are appropriately reported together under the particular circumstances and (2) it would not be more appropriate to append any other CPT®-modifier to such code or codes. §7.20(b)(vi). | the extent that (1) although such procedures or services are not normally reported together they are appropriately reported together under the particular presenting circumstances; (2) it would not be more appropriate to append any other CPT® recognized modifier to such codes; and (3) to the extent that the CPT® Code submitted for payment with a modifier 59 attached is otherwise subject to a Claim Coding and Bundling edit, substantiating Clinical Information indicates that the use of Modifier 59 was appropriate (which requirement shall be posted on the Website consistent with Section7.8.(c) of this Agreement) §7.20(g). | |

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| **Global Periods** | | o global periods for surgical procedures shall be longer than any period then designated on a national basis by CMS for such surgical procedures. §7.20(b)(vii). | No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict CIGNA HealthCare from establishing a global period for surgical procedures (except where CMS has determined a global period is not appropriate or has identified a global period not associated with a specific number of days). §7.20(h). | None |
| **Automatic Downcoding of Service Intensity** | | Aetna shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® code is one among a series that differentiates among simple, intermediate and complex. §7.20(b)(viii). | CIGNA HealthCare shall not automatically change a code to one reflecting a reduced intensity of the service when such CPT® Code is one among a series that differentiates among simple, intermediate and complex; | None. |
| | | | provided that, consistent with Section 7.8.c of this Agreement, nothing in this Section 7.20.i shall preclude CIGNA HealthCare from requiring the submission of Clinical Information substantiating that the requirements for intermediate and complex versions of the service have been satisfied. §7.20(i). | |

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| **Annual Update of Modifier 51 exempt Codes** | | By May 6, 2004, or as soon thereafter as is reasonably practicable, Aetna shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or any reclassifications of existing CPT® Codes as modifier 51 exempt since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above Aetna shall not be obligated to take any action prior to the effective date of the additions or reclassifications. §7.20(b)(ix)., | CIGNA HealthCare shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or any reclassifications of existing CPT® Codes as modifier 51 exempt since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above, CIGNA HealthCare shall not be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require CIGNA HealthCare to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any Plan Member's Plan, and nothing in this subparagraph shall be | None. |
| | | | interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year. §7.20(d). | |
| **Non-exclusive Listing of Modifiers** | | Nothing contained in this section shall be construed to limit Aetna's recognition of modifiers to those modifiers specifically addressed in this Section. §7.20(x). | Nothing contained in this Section shall be construed to limit CIGNA HealthCare's recognition of modifiers to those modifiers specifically addressed in this Section. §7.20(j). | None. |

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| **Record Review Permitted** | | Notwithstanding anything to the contrary in this Section. Aetna shall continue to have the right to deny or pend claims based on a review of relevant medical records or based on a review of information derived from Aetna's fraud and abuse detection programs that creates a reasonable belief of fraudulent abusive or other inappropriate billing practices, or other tools that reasonably identify inappropriate billing. §7.20., | Nothing in this Section is intended or shall be construed to require CIGNA HealthCare to pay for anything other than Covered Services for CIGNA HealthCare Members, to make payment at any particular rates, to limit CIGNA HealthCare's right to deny or adjust claims based on reasonable belief of fraudulent, abusive or other inappropriate billing practices (so long as the Class Member has had the opportunity to invoke the provisions of Section 7.12) or to supersede Individually Negotiated Contracts that specifically provide for alternative payment logic. §7.20. | None |
| **Rescission or Modification of Authorized Prohibited** | | If Aetna certifies that a proposed treatment is medically necessary for a particular Plan Member, Aetna shall not subsequently revoke that medical necessity determination absent evidence of fraud, evidence that the information submitted was materially erroneous or | If CIGNA HealthCare certifies that a proposed treatment is Medically Necessary for a particular CIGNA HealthCare Member, CIGNA HealthCare shall not subsequently revoke that Medical Necessity determination absent evidence of fraud, evidence that the | None. |
| | | incomplete, or evidence of material change in the Plan Member's health condition between the date that the certification was provided and the date of the treatment that makes the proposed treatment inappropriate for such Plan Member. In the event that Aetna certifies the medical necessity of a course of treatment limited by number, time period or otherwise, then a | information submitted was materially erroneous or incomplete, or evidence of material change in the CIGNA HealthCare Member's health condition between the date that the certification was provided and the date of the treatment that makes the proposed treatment not Medically Necessary for such CIGNA HealthCare Member. In the event that CIGNA HealthCare | |

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| | | request for treatment beyond the certified course of treatment shall be deemed to be a new request and Aetna's denial of such request shall not be deemed to be inconsistent with the preceding sentence. §7.25. | certifies the Medical Necessity of a course of treatment limited by number, time period or otherwise, then a request for treatment beyond the certified course of treatment shall be deemed to be a new request and CIGNA HealthCare's denial of such request shall not be deemed to be inconsistent with the preceding sentence. §7.25 | |
| **Timely Payment** | Insurance Law section 3224-a requires HMO's and insurers to pay claims and bills within 45 days of receipt, except in cases where the obligation to make payment is not reasonably clear or where there is evidence that the bill may be fraudulent.<br><br>In cases where the obligation to pay is not clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation for all or part of the claim, the amount of the claim, the benefits covered under the agreement, or the manner in which services were accessed or provided, the HMO or insurer must pay the undisputed portion of the claim within 45 days. The HMO or insurer must notify the covered person or health care provider in writing within 30 days of receipt of the claim: (1) that it is not obligated to pay the claims or make the medical payment, stating the specific reasons why it is not liable; or (2) to request all | These initiatives include, among other things, a practice of making up to three (3) inquiries for additional information upon receipt of incomplete claims from physicians before denying such claims. Company agrees to continue these or comparable business practices during the Effective Period. §7.7.<br>By May 6, 2004, Aetna's voice response telephone system shall permit a Physician to determine the date on which a submitted claim was determined by Aetna to constitute a Clean Claim. Aetna shall date stamp paper | CIGNA HealthCare has developed, will implement and will maintain at least until the Termination Date processes to send next-Business Day written communications to Physicians when it is determined that additional information is necessary to process a claim, explaining the information needed, and to send two written reminders at thirty (30) days and sixty (60) days if the necessary information has not been received in response to the initial communication. If the necessary information has not been received at ninety (90) days, then | ERISA group health plans must notify claimants of an adverse benefit determination not later than 30 days after receipt of the claim, unless extended for up to 15 days for good cause. If an extension is necessary for lack of information, the notice of extension must specifically describe the required information and give the claimant at least 45 days from receipt of the notice to provide it. 29 C.F.R. §2560.503-1(f)(iii)B).<br><br>Claimants (ERISA beneficiaries or physicians acting as their |

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| | additional information needed to determine to pay the claim or make the health care payment.<br><br>Each claim or bill processed after the 45 day period is a separate violation. Interest must be paid at the greater of 12 per cent per year or the corporate tax rate determined by the Commissioner of Taxation and Finance. When the amount of interest due on a claim is less than two dollars, the HMO or insurer are not required to pay interest on the claim.<br><br>Superintendent of Insurance may impose a penalty of up to $500 per claim for each day a claim is processed beyond the 45 day limit. The five is capped at $5,000 for each separate violation. | | | |
| | | claims for Covered Services upon receipt in the mailroom and generate an electronic acknowledgment of receipt of electronic claims for Covered Services when received by applicable Aetna computer system.<br>Aetna shall direct the issuance of a check or electronic funds transfer in payment for Clean Claims for Covered Services within the following time periods, in each case measured from the later of Aetna's receipt of such claim or the date on which Aetna is in receipt of all information needed and in a format required for such claim to constitute a Clean Claim, | the claim will be denied at that time, and the Physician may appeal pursuant to 7.10 or 7.11. If CIGNA HealthCare obtains information prior to that time showing that the claim should be denied, CIGNA HealthCare will promptly deny the claim, so that the Physician may pursue any other remedies the Physician may have. If the denial is based on eligibility of the patient, the Physician may directly bill the patient.<br>Every claim received by CIGNA HealthCare is and at least until the Termination Date will be logged with a receipt date whether the claim is received on paper or electronically. CIGNA | authorized representative pursuant to 29 C.F.R. §2560.503-1(b)(4)) are entitled to sue in federal court if their claim has not been paid or denied within the timeframe set forth above. 29 C.F.R. §2560.503-1(l). |

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| | | including without limitation all documentation reasonably needed by Aetna to determine that such claim does not contain any material defect or error; provided that nothing contained herein is intended or shall be construed to alter Aetna's ability to request documentation consistent with the provisions of this Settlement Agreement 15 days for claims that Physicians submit electronically and 30 days for claims that Physicians submit on paper forms. Beginning November 6, 2004, for each Clean Claim with respect to which Aetna has directed the issuance of a check or electronic funds transfer later than the applicable period specified in the preceding sentence Aetna shall pay interest at the lesser of the | HealthCare will continue to pursue initiatives designed to improve the timeliness of claim processing and shall attempt to include in its contracts with each clearinghouse a requirement that each such clearinghouse transmit claims to CIGNA HealthCare within twenty four (24) hours after such clearinghouse's receipt thereof.<br>§7.7 and §7.18(a).<br>CIGNA HealthCare shall pay simple interest of six percent (6%) per annum on the balance due on all claims submitted by Class Members that are processed and finalized for payment more than thirty (30) calendar days following the submission of all information necessary to make the claim complete. | |
| | | prime rate and eight percent (8%) per annum on the balance due on each such claim from the end of the applicable specified period up to but excluding the date on which Aetna issues the check (or issues instructions for electronic funds transfer) for payment of such Clean Claim; provided that to the extent that payment is made later than the period specified by applicable law, Aetna shall pay interest at any rate specified by such law or regulation in lieu of the interest payment otherwise contemplated by this sentence.<br>Notwithstanding the foregoing, Aetna shall have no obligation to make any interest payment (i) | Beginning one year following Final Approval, for claims processed on either of the new systems referenced above, CIGNA HealthCare shall pay simple interest of six percent (6%) per annum on the balance due on all claims submitted electronically by Class Members that are processed and finalized for payment more than fifteen (15) business days following the submission of all information necessary to make the claim complete.<br>Notwithstanding the foregoing, if CIGNA HealthCare determines that an applicable state law or regulation requires interest to be computed and paid | |

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| | | with respect to any Clean Claim if, within 30 days of the submission of an original claim, a duplicate claim is submitted while adjudication of the original claim is still in process; (ii) to any Participating Physician who balance bills a Plan Member in violation of such Participating Physician's agreement(s) with Aetna; or (iii) with respect to any time period during which a Force Majeure prevents adjudication of claims. Aetna shall attempt to include in its contracts with each clearinghouse a requirement that each such clearinghouse transmit claims to Aetna within twenty four (24) hours after such clearinghouse's receipt thereof. §7.18. | at a different interest rate, CIGNA HealthCare shall observe the requirements of that state law or regulation. Underthis provision, simple interest shall be computed from the sixteenth (16th) or the thirty-first (31st) day (as appropriate based on the circumstances described above) after CIGNA HealthCare receives the information necessary to make the claim complete to the date on which the claim is processed by CIGNA HealthCare and placed in line for payment. Interest so computed shall, at CIGNA HealthCare's election, either be included in the claim payment check or wire transfer or be remitted in a separate check or wire transfer. Notwithstanding the terms of |
| | | | this subparagraph, CIGNA HealthCare shall have no obligation to make any interest payment on any such claim as to which (i) the Class Member , within thirty (30) days of the submission of an original claim, submits a duplicate claim while the original claim is still being processed; or (ii) the Class Member violates the terms of his, her or its contract with CIGNA HealthCare by inappropriately billing a CIGNA HealthCare Member for the balance due from CIGNA HealthCare. In addition, with respect to interest payments that total less than One Dollar ($1.00) on any single claim ("de minimis | |

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| | | | interest"), CIGNA HealthCare may, at its sole option, either (i) pay such amounts in the same manner as any other interest payment under this paragraph, or (ii) if it determines that it cannot practically pay using option (i), calculate the total dollar amount of de minimis interest for each year during the period for which this Section, and pay such amount to the Foundation created by the Settlement Agreement.<br>If CIGNA HealthCare elects to pay this interest to the Foundation, (the calculation of de minimis interest will be determined by a claim audit based on statistically valid claim audit procedures and will include interest on the de minimis interest for the preceding year, | |
| | | | which interest of six percent (6%) per annum will be calculated on a reasonable basis. CIGNA HealthCare will provide the audits to Notice Counsel. §7.18(b). | |
| **Unfair Records Requests** | N.Y.S Department of Health regulations, 10 N.Y.C.R.R. § 98-1.12(j), provides that the HMO shall require that medical records of enrollees are retained for six years after the date of service rendered to enrollees or cessation of HMO operation, and in the case of a minor, for six years after majority.<br><br>N.Y.S. Department of Health regulation, 10 N.Y.C.R.R. § 98- | Aetna shall not routinely require submission of clinical records before or after payment of claims, except as to claims for unlisted codes, claims to which a modifier 22 is appended, and other limited categories of claims as to which Aetna subsequently determines that routine review of medical records is appropriate; provided that if Aetna subsequently determines to routinely require submission of | CIGNA HealthCare shall not routinely require submission of Clinical Information before or after payment of claims. Notwithstanding the foregoing, (i) CIGNA HealthCare may require submission of Clinical Information before or after payment of certain categories of claims and shall promptly disclose on the Website any such claim category or categories; CIGNA HealthCare may require | ERISA group health plans must calculate timeframes for decisions based on when the claim is filed, regardless of whether the plan believes medical records are necessary to adjudicate the claim. 29 C.F.R. §2560.503-1)(f)(4).<br><br>Except with respect to claims involving urgent care, group health plans may unilaterally extend the time frames by 15 |

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| | 1.13(g), provides that the HMO shall insure that it has access to the medical records of enrollees upon request by the HMO and the Department of Health. The HMO must assure access through explicit provision in the contracts between the HMO and any providers of services. | clinical records before or after payment of a specified category of claims, Aetna shall promptly disclose on the Public Website and the Provider Website any such claim category or categories. Notwithstanding the foregoing, Aetna may require submission of clinical records before or after payment of claims for the purpose of investigating fraudulent, abusive or other inappropriate billing practices but only so long as, and only during such times as, Aetna has reasonable basis for believing that such investigation is warranted and Physicians may contest such requirement pursuant to the External Billing Review process discussed below. Aetna also has the right to require submission of medical | submission of Clinical Information before or after payment of claims for the purpose of investigating fraudulent, abusive or other inappropriate billing practices but only so long as, and only during such times as, CIGNA HealthCare has a reasonable basis for believing that such investigation is warranted and Physicians may contest such requirement pursuant to the External Review Billing process discussed below. CIGNA HealthCare also has the right to require submission of Clinical Information for pre-certification purpose. §7.8(c). | days. If the claimant is notified about the need for additional information, the time period for making a decision is tolled until the plan receives the information or the deadline the plan establishes (which must be at least 45 days). 29 C.F.R. §2560.503-1(f) and (i).<br><br>Alternatively, a plan may deny the claim based on insufficient information. The denial would allow the claimant to move to the next level of the claims process. Frequently Asked Questions About The Benefits of Claim Procedure Regulation (FAQ) C-2, C-22. |
| | | records for pre-certification purposes. §7.8(c)(ii). | | |
| **Non-contract UCR Determinations** | | Representative Plaintiffs, Class Counsel and Aetna agree that this Agreement is not intended to alter or change the rights of a Non-Participating Physician to balance bill or to bill the Plan Member at rates and on terms that are agreed to between the Non-Participating Physician and the Plan Member. §7.21(b). | If CIGNA HealthCare uses databases licensed from one or more third parties in order to determine "reasonable and customary" billed charges in the medical community, those databases shall be identified. §7.2(a)(2)(l).<br><br>If a Non-Participating Class Member initiates a dispute using CIGNA HealthCare's internal dispute resolution procedures over how CIGNA HealthCare has determined the "reasonable and customary" charge for a | None. |

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| | | | given health care service or supply and, consequently, over how CIGNA HealthCare has computed the benefits payable for that health care service or supply, CIGNA HealthCare shall disclose to the Class Member initiating the dispute the data used by CIGNA HealthCare to determine the "reasonable and customary" charge for that given health care service or supply. §7.14(c).<br><br>Nothing in this Agreement is intended to, and shall not, alter or change the rights of Non-Participating Physicians to balance bill or to bill a CIGNA HealthCare Member at rates and on terms that are agreed between the Non-Participating Physician and the CIGNA HealthCare | |
| | | | Member. §7.21(b). | |
| **EOB Disclosures** | Every insurer, including HMO, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claims under a policy providing coverage for hospital or medical expenses. The explanation of benefits must include at least the following:<br><br>(1) the name of the provider of service; the admission or financial control number, if applicable;<br>(2) the date of service;<br>(3) an identification of the service for which the claim is | Aetna shall expend resources reasonably sufficient, with cost to Aetna not to exceed $4,000,000, to revise by December 31, 2003 or as soon thereafter as practicable, the EOB forms for its traditional products to contain at least: the name of and a number identifying the Plan Member, the date of service, the amount of payment per line item, any adjustment to the invoice submitted and generic explanation therefore in compliance with HIPAA requirements and such EOB | CIGNA HealthCare shall use its best efforts to identify on those Remittance Forms issued to Class Members the following information: the name of and a number identifying the CIGNA HealthCare Member, the date of service, the amount of payment per line item, any adjustment to the invoice submitted and generic explanation therefore in compliance with Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requirements, all billing codes submitted by the Class Members and the distinct | ERISA group health plans reference the specific plan provisions in which the determination is based and must either include the rule, protocol or guideline relied upon in making an adverse determination, or it must indicate that such was relied on and that it will be provided free-of-charge on request. 29 C.F.R. §2560.503-1(g)(1)(v) and (j); FAQ C-16 ad C-17. |

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| | made;<br>(4) the provider's charge or rate;<br>(5) the amount or percentage payable under the policy after deductibles; co-payments, and any other reduction of the amount claimed;<br>(6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed;<br>(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought, and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request of clarification is made.<br><br>Except on demand by the insured or subscriber, insurers or HMOs are not required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer's program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid by the insurer | shall specify an address and phone number for questions regarding the claim described on such EOB. Consistent with the desire that Plan Members receive accurate communications that do not disparage Non-Participating Physicians, each such EOB shall indicate the amount for which the Physician may bill the Member and state "Physician may bill you" such amount, or contain language to substantially similar effect, and shall not characterize disallowed amounts as unreasonable. The explanation of payment or similar forms that Aetna sends to Physicians communicating the results of claims adjudications shall contain at least: the name of and a number identifying the Plan Member, the date of | charges therefore, and, whether such codes were paid or denied, and, if denied, the reasons therefore, and an address and telephone number for questions regarding the claim described in the Remittance Form. Such Remittance Forms shall also contain a printed disclosure advising Class Members that reconsideration of the application of any denied billing codes, regardless of the reason for the denial, is available through CIGNA HealthCare's appeal procedures, which procedures may require the submission of relevant Clinical Information. The Settling Parties recognize that certain claim processing systems currently in use at CIGNA HealthCare cannot immediately | |

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| | directly to the participating facility or provider. | | | |
| | | service, the amount of payment per line item**,** the procedure code(s), the amount of payment, any adjustment to the invoice submitted and generic explanation therefore in compliance with HIPAA requirements, as well as any adjustment or change in any code on a line by line basis, and shall specify an address and phone number for questions by the Physician regarding the claim described on such explanation of payment or comparable form. The forgoing sentence is not intended and shall not be construed to limit Aetna's right to replace the communications referred to in the preceding sentence with electronic remittance advices or the equivalent, to the extent such electronic remittances or the equivalent provide similar information and are consistent with legal requirements. §7.21(a). | meet this requirement and that implementation of this specification will require the migration of claim processing activity to other claim processing systems that already meet this specification. The Settling Parties recognize that this migration effort, which is already underway, is a complex effort that will occur over time. Accordingly, CIGNA HealthCare shall provide quarterly status reports to Notice Counsel regarding its efforts to meet this specification, and shall report to Notice Counsel when the efforts are complete. Once this process of migration has been completed and Notice Counsel have been so advised, Remittance Forms shall continue to identify all distinct billing codes submitted by Class Members at least through the Termination Date. §7.21(a). | |
| **Claims Filing Deadlines** | | Except to the extent otherwise expressly specified by a Self-Funded Plan, Aetna shall not contest the timeliness of bills for Covered Services if such bills are received within 120 days after the later of: (i) the date of service and (ii) the date of the Physician's receipt of an EOB from the primary payor, when | Except where CIGNA HealthCare and a Class Member have entered into an Individually Negotiated Contract that provides for a different submission period, CIGNA HealthCare shall treat all claims submitted within one hundred eighty (180) days of the date of service as timely. With respect to | ERISA group health plans must establish and maintain reasonable procedures governing the filing of claim which do not contain any provision and which are not administered in any way that "unduly inhibits or hampers the initiation or processing of claims for benefits." 29 C.C.R. §2560.503-1(b)(3). The DOL has |

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| | | Aetna is the secondary payor. Aetna shall recommend to Self-Funded Plan sponsors that they adopt the 120 day time period | claims submitted more than one hundred eighty (180) days after the date of service, CIGNA HealthCare shall specify on its | opined that "adoption of a period of time for filing claims that serves to unduly limit claimant's reasonable, good faith |
| | | referenced in the preceding sentence. Aetna shall waive the above requirement for a reasonable period in the event that Physician provides notice to Aetna, along with appropriate evidence, of extraordinary circumstances that resulted in the delayed submission. Aetna shall determine "extraordinary circumstances" and the reasonableness of the submission date. 7.17(a). | Website those circumstances under which such claims shall be accepted for processing and, if appropriate, for payment. §7.17(a). | efforts to make claims for and obtain benefits under the plan would violate this requirement. FAQ C-19 |
| **Misdirected Claims** | | None. | None. | None. |
| **Acknowledgment of Claim Receipt** | | None. | None. | None. |
| **Overpayments** | | Aetna shall initiate or continue to take actions reasonably designed to reduce Overpayments. Such actions may include, without limitation, system enhancements to identify duplicate invoices prior to payment and construction and maintenance of a common Physician database for use in connection with payment of Physician invoices. Aetna shall publish on the Public Website and the Provider Website an address and procedures for Physicians to return Overpayments. In addition, other than for recovery | CIGNA HealthCare shall initiate or continue to take actions reasonably designed to reduce Overpayments, and it shall publish on its Website an address and procedures for Class Members to return Overpayments. In addition, other than for recovery of duplicate payments, CIGNA HealthCare shall provide Class Members with 30 days written notice before seeking Overpayment recovery, whether or not the Overpayment occurred during the Class Period or afterward. The notice shall | None. |

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| | | of duplicate payments, Aetna shall provide Physicians with 30 days written notice before initiating Overpayment recovery | state the patient name, service date, payment amount, proposed adjustment, and explanation or other information (including | |
| | | efforts. The notice shall state the patient name, service date, payment amount, proposed adjustment, and explanation or other information (including without limitation procedure code, where appropriate) giving Physicians reasonably specific notice of the proposed adjustment.<br>Aetna shall not initiate Overpayment recovery efforts more than 24 months after the original payment; provided that no time limit shall apply to initiation of Overpayment recovery efforts based on reasonable suspicion of fraud or other intentional misconduct or initiated at the request of a Self-Funded Plan, and in the event that a Physician asserts a claim of underpayment Aetna may defend or set off such claim based on Overpayments going back in time as far as the claimed underpayment. §7.22 | without limitation procedure code, where appropriate) giving Class Members reasonably specific notice of the proposed adjustment. CIGNA HealthCare shall not initiate Overpayment recovery efforts more than twelve (12) months after the original payment; provided that no time limit shall apply to initiation of Overpayment recovery efforts based on reasonable suspicion of fraud or other intentional misconduct or initiated at the request of a Self-Insured Plan; and in the event that a Class Member asserts a claim of underpayment, CIGNA HealthCare may defend or set off such claim or it may counterclaim based on. Overpayments going back in time as far as the claimed underpayment. §7.22 | |
| **Contract Modifications** | | Aetna agrees to update those fee schedules annually, and shall not reduce any scheduled fees for Physician Services, except to reflect changes in the marketprice for vaccines, pharmaceuticals, durable medical supplies or other goods or non-physician services, and to update physician fee schedules to add payment rates for newly adopted | IGNA HealthCare agrees not to reduce its fee schedule for a Participating Physician more than once a calendar year (except to reflect changes in the marketprice for vaccines, pharmaceuticals, durable medical supplies or other goods or non-physician services, and to update physician fee schedules to add payment rates for newly adopted | None. |

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| | | CPT Codes, new technologies, new uses of established technologies, and any interim revisions made by CMS between | CPT Codes, new technologies, new uses of established technologies, and any interim revisions made by CMS and shall | |
| | | such annual updates. *(Excerpted from §7.14)*<br>Aetna shall provide Participating Physicians with 90 days' advance notice of all planned Material Adverse Changes to Aetna's policies and procedures affecting performance under contracts with Participating Physicians, except to the extent that a shorter notice period is required to comply with changes in applicable laws. §7.6. | give notice of any such change as a material adverse change subject to the provisions of Section 7.6 set forth below. In the first year of a physician's contract, a change in fee schedule may be made before December 31st of the year in which the contract became effective. *(Excerpted from §7.14)*<br>CIGNA HealthCare shall, if it intends to make a material adverse change in the terms of contracts with Participating Physicians, give ninety (90) days written notice to each Participating Physician affected thereby (except to the extent that a shorter notice period is required to comply with changes in applicable law) and the change shall become effective at the conclusion of the ninety (90) day notice period. §7.6. | |

[1]During the regulatory process, the DMHC stated that "a payor who utilizes unknown or archaic terminology is likely to cause delays in claims payment processing because providers will be unfamiliar with its unusual billing/coding requirements. There is simply no reason to use unique or outdated billing standards when nationally recognized standards, familiar to payors and provides, are readily available—except to delay payments." See DMHC Responses to Comments, 1st Comment Period, No. 153. In addition, some providers noted that there may be some instances in which payment criteria, or the criteria used for the denial of payment, has been aided by claims fraud detection software and that it would be helpful for providers to know the source of the claims review. On that point, the DMHC stated:

> The revised regulations require that the payor make the information disclosures in sufficient detail and in an understandable format so that a reasonable person with sufficient training and experience in claims processing can determine what payment is to be made in accordance with the contract. While the disclosure of claims fraud detection software is not specifically mandated, if [it] the substance of this information is necessary for the provider to determine the payment to be made according to the contract it must be disclosed in some understandable format. See DMHC Responses to Comments, 1st Comment Period, No. 163.

[1] The DMHC rejected payors' concerns that the term "non-standard coding methodologies" was unclear, stating no further definition is necessary and appropriate and that "if a plan provides its detailed payment policies, its non-standard coding methodologies must be included." See DMHC Responses to Comments, 2nd Comment Period, No. 318.

[1]The DMHC did not believe it appropriate to specify the "HCFA current procedural coding system (HCPCP) code levels" but stated such a "reference would not be prohibited." See DMHC Responses to Comments, 1st Comment Period, No. 150.

[1]CMA fought, and remains somewhat concerned about the aspects of the regulations that protect trade secrets, copyright laws or patented processes as they could be wrongly interpreted as an overly broad exception to disclosure. The DMHC still believes that full disclosure is appropriate, stating:

[5]The revised regulations require full disclosure of a plan's payment rules. It merely states that the format of this disclosure should not violate trade secrets or copyright laws.

See DMHC Responses to Comments, 2nd Comment Period, No. 324.

[1]"Day of receipt" means the working day when a claim, by physical or electronic means, is first delivered to the plan's specified claims payment office, post office box, or designated claims processor, or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code §641. In the situation where the claim is sent to the incorrect party, the "day of receipt" is the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim. (28 C.C.R. §1300.71(a)(6).)

[1]28 C.C.R. §1300.71(b).

[1]The "Date of Payment" is the date of the postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail service, correctly addressed to the claimant's office or other address of record. (28 C.C.R. §1300.71(a)(5).)

[1]The DMHC also does not believe that automatic offsetting should be allowed in non-contracting settings. See DMHC Responses to Comments, 2nd Comment Period, No. 240.