

MISSION & ME
PARTNERSHIP FOR A HEALTHY FUTURE

& you!

Provider Summit

MISSION & ME
PARTNERSHIP FOR A HEALTHY FUTURE

Today's Discussion

- **Mission's strategic health benefits goals**
- **Why we went through a due-diligence process**
- **What's changing (and what is staying the same)**
- **Our new health plan administrator – CIGNA**
- **How CIGNA's plan administration works**
- **Tools and resources you can use**
- **Where to go/who to call**
- **Question/answer session**



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This presentation was developed for Mission's Provider Summit held on December 16, 2008, which was intended to communicate changes in Mission's health plans effective January 1, 2009.

This version of the presentation is being made available to providers as a reference document on Mission's plans and includes information on Mission's plan design and disease management programs. Additionally, details on CIGNA's administrative processes and procedures are provided, along with contact information for EAN, Crescent and CIGNA.

IMPORTANT:

It is important to note that **MISSION IS NOT UTILIZING CIGNA'S PROVIDER NETWORK** (with the exception of transplants). CIGNA is replacing Wells Fargo TPA for plan and claim administration services. However, CIGNA is **NOT REPLACING EAN or Crescent**.

Beginning on January 1, 2009, the Crescent provider withhold will no longer be applied to claim payments. Mission will be paying an access fee directly to Crescent which will replace the provider withhold payments.

Key Contributors to Mission's Health Plan Strategy

- **Mission Human Resources**
- **BenRx Benefits Consulting**
- **Employee Focus Groups**
- **American Health Care**
- **CIGNA Healthcare**
- **Provider Focus Group #1**
- **Provider Focus Group #2**
- **EAN (Employee Assistance Network)**
- **Crescent PPO**



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Multiple key constituents contributed to Mission's 2009 health plan strategy.

Feedback from providers, particularly with respect to health plan administrators (Aetna, CIGNA, United, WellPath, etc.), weighed heavily in the decisions made by Mission.

Our Strategic Goals

- **Significantly improve plan administration and service to employees and providers**
- **Engage our people in a meaningful and sustained way**
- **Make measurable contributions to improving staff health and wellness**
- **Complement internal disease management programs**
- **Re-brand and re-communicate a total health management program**
- **Manage total cost at the most efficient level possible while supporting a highly competitive health plan**



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Employee and provider dissatisfaction with our health plan reached unacceptable levels in 2008. For 2009, our primary objective is to improve plan administration and service to our employees and providers.

To support our efforts, we are re-branding and re-communicating our total health management program. As part of this effort, we sought feedback directly from providers through provider focus group sessions. This special Provider Summit (December 16, 2008) and our presentation to the Western North Carolina Medical Group Practice Managers association (January 14, 2009) are designed to help providers understand our benefits program, key changes taking place with CIGNA, and where to go for help if needed.

While improving satisfaction is our primary goal for 2009, we also have a highly active strategy to get and keep our people engaged in improving health and managing chronic conditions through our nationally-recognized disease management programs. We know that keeping our people healthy is the best way to manage our overall health benefits cost.

Due Diligence Process

Key Milestone	Timing
1. Benchmark health plan design, overall coverage, and premium contribution levels	December 2007 – March 2008
2. Understand and define key Mission requirements, employee & provider needs and concerns <ul style="list-style-type: none"> • Employee focus groups • Individual employee meetings • Department meetings • Practice manager focus groups 	April – July 2008
3. Request-for-Proposal to identify best-in-class consumer-driven health plan vendors with the following capabilities: <ul style="list-style-type: none"> • administer current network • more efficient, effective claim processing • improved service delivery for participants, providers, and Mission's HR team • effectively support and work with Mission's disease management programs 	July – August 2008
4. Conduct detailed, facilitated interviews with Aetna, CIGNA, United, WellPath	July – August 2008
5. Ongoing negotiation with finalists	August – Sept 2008
6. Administration awarded to CIGNA beginning 1/1/2009	October 2008

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Why We Selected CIGNA

- **Commitment to work with our unique client-specific networks and approaches**
 - Crescent PPO, direct contracts, and Employee Assistance Network [EAN]
 - Mission's internal disease management programs (My Healthy Life)
- **Experience with hospital systems and consumer-directed health plans**
- **A top-notch account management and implementation team**
- **A dedicated CDH service center team with excellent service results**
- **High marks from the provider community**



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We evaluated potential health plan administrators with a strong eye to who could deliver the greatest service improvement while at the same time administering our highly unique provider network AND a Consumer-Directed Health Plan like ours.

Overall, CIGNA scored the best, and was the most highly-rated (of all the major carriers) in service delivery.

What's Changing – and What's Not

Benefit/Service/Coverage	2008	2009
Medical	Wells Fargo TPA (WFTPA)	CIGNA
PPO Network	Custom network comprised of Crescent PPO, Employee Assistance Network (EAN) behavioral health providers, and directly-contracted providers.	No change
Rx Benefit Manager (complete carve-out)	American Health Care	No change
Dental	WFTPA	CIGNA
HRA (Health Reimbursement Account)	WFTPA/Evolution Benefits	CIGNA
FSA (Flexible Spending Account)	WFTPA/Evolution Benefits	CIGNA
HRA Debit Card	Evolution Benefits/Benny Card	No Benny Card or other form of debit card is applicable to HRA
COBRA	WFTPA	Ceridian
Transplant network	URN – United Resource Network	CIGNA LifeSOURCE Network
Disease management	Mission	No change
Health promotion	Mission	No change

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This slide summarizes the key changes in Mission's health benefits plan in 2009.

The most significant change is that the BennyCard is being eliminated effective January 1, 2009. The BennyCard was the health care debit card used to access employees' Health Reimbursement Account (HRA) and Flexible Spending Account (FSA).

Instead of using a debit card at the time services are received, CIGNA will *automatically* apply a Mission plan member's HRA fund to any financial responsibility (like deductible and coinsurance) when the claim is submitted for processing. This process, which is in part intended to minimize collection problems, is discussed later in this presentation.

What's Changing – and What's Not

New branding for Mission's benefits!

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2008 Plan Name	New 2009 Plan Names
Choice Plan	Mission CDH
Catastrophic Plan	Mission Basic
	Mission PPO <i>New for 2009!</i>



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In 2008, Mission offered employees a choice of two health benefits plans: the Choice Plan (a consumer-directed health plan that includes a health reimbursement account) and a catastrophic plan.

As part of the rebranding effort discussed earlier, the Choice Plan and Catastrophic plans have been re-named. In addition, we've added a new plan option, the Mission PPO, for 2009. This new option is a co-pay-driven plan similar to a plan that Mission had in place up until 2007.

What's Changing – and What's Not

MyHealthyLife

HEALTH ENHANCEMENT & DISEASE MANAGEMENT

New branding for Mission's disease management programs!

Classes:

- Diabetes classes: series of 5 classes
- High blood pressure: series of 3 classes
- Asthma & COPD: individual education sessions with an educator
- Depression: No classes

Care Manager:

- In MOST cases, the care manager is a Mission employee . May also be a community pharmacist.
- Participant *must* meet with care manager at least quarterly (with a commitment to meet as frequently as once a month if requested by their case manager)
- Missed visits are cause for disenrollment in the program

PLEASE REMIND PATIENTS ABOUT MISSION'S MY HEALTHY LIFE PROGRAMS

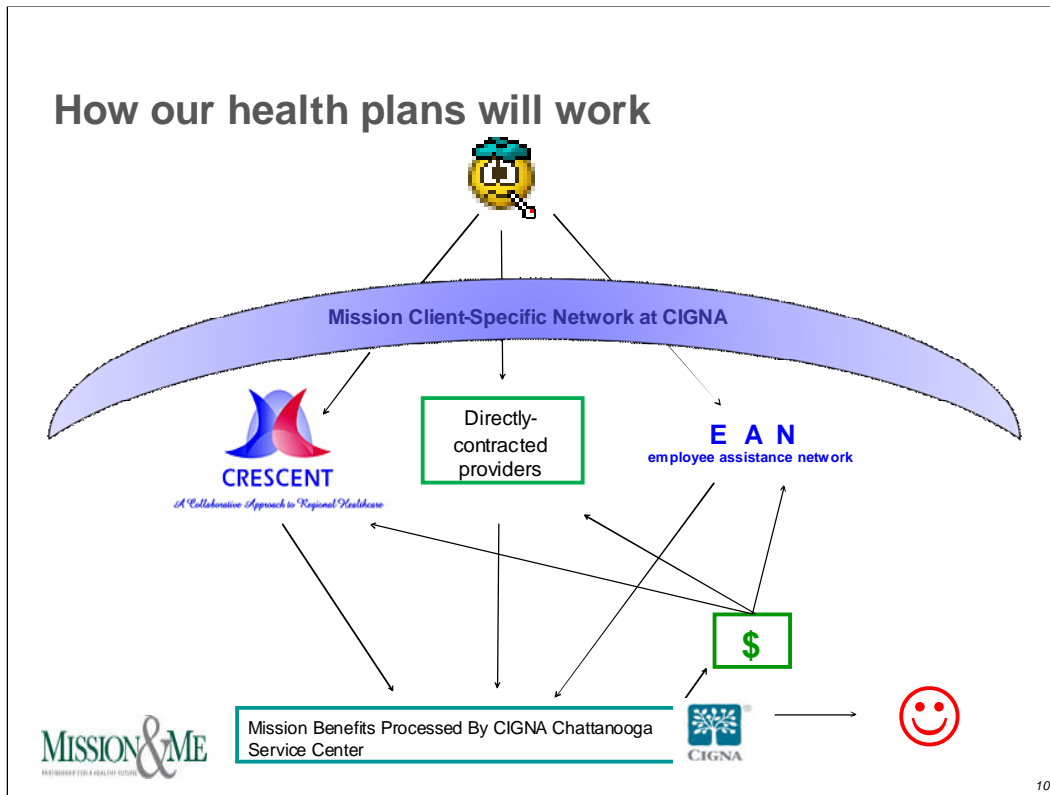
Programs cover diabetes, high blood pressure, high cholesterol, asthma/COPD, and depression. Once enrolled, the participant receives enhanced benefits (for both Rx plan and the health plan) for certain Rx and medical services related

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As you know, Mission is committed to having a healthy workforce. This is demonstrated through Mission's commitment to health enhancement and disease management. For 2009, these programs have been rebranded with the moniker "My Healthy Life."

PLEASE REMIND YOUR PATIENTS ABOUT MISSION'S MyHealthyLife PROGRAMS.

Patients who participate receive enhanced plan benefits relating to their underlying medical condition. Additionally, participants in the MyHealthyLife program receive coaching and guidance from specialized care managers to help implement the health care regimen recommended by their physician(s).



We want to reinforce that we are not using CIGNA’s provider network.

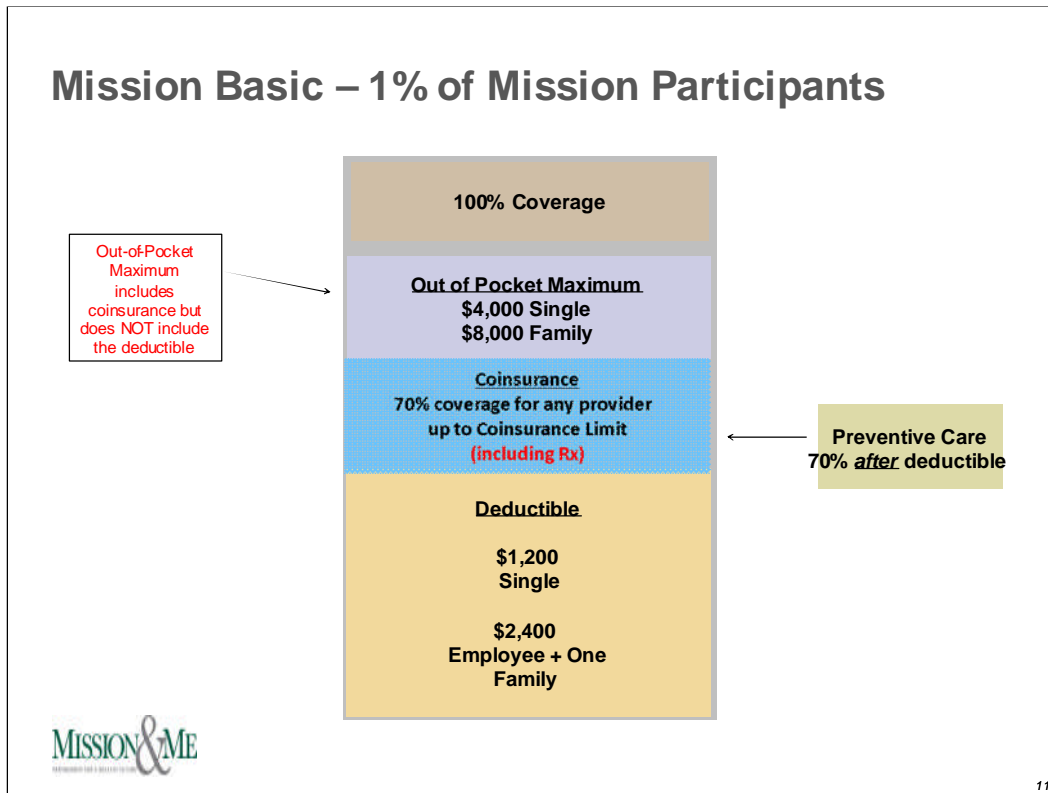
Our underlying provider network, which consists of providers contracted primarily through Crescent, EAN (for behavioral health), and in some cases through direct contracts, is NOT changing as the result of the change in TPA services. CIGNA is replacing Wells Fargo for *administrative services* to our health plan.

Claims and calls will be handled in CIGNA’s Chattanooga, TN service center. The unit that is handling Mission’s claims and calls specializes in Consumer-Directed Health Plans (like Mission’s CDH program).

IMPORTANT: IN ORDER TO BE DIRECTED TO THE CIGNA UNIT HANDLING MISSION, IT IS IMPORTANT TO ALWAYS HAVE THE MEMBER’S IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER WHEN CALLING.

- Providers who call CIGNA without this information will have their calls routed to any of CIGNA’s service centers.
- *Only* the Chattanooga Center has had special training on Mission’s plans!

Mission Basic – 1% of Mission Participants



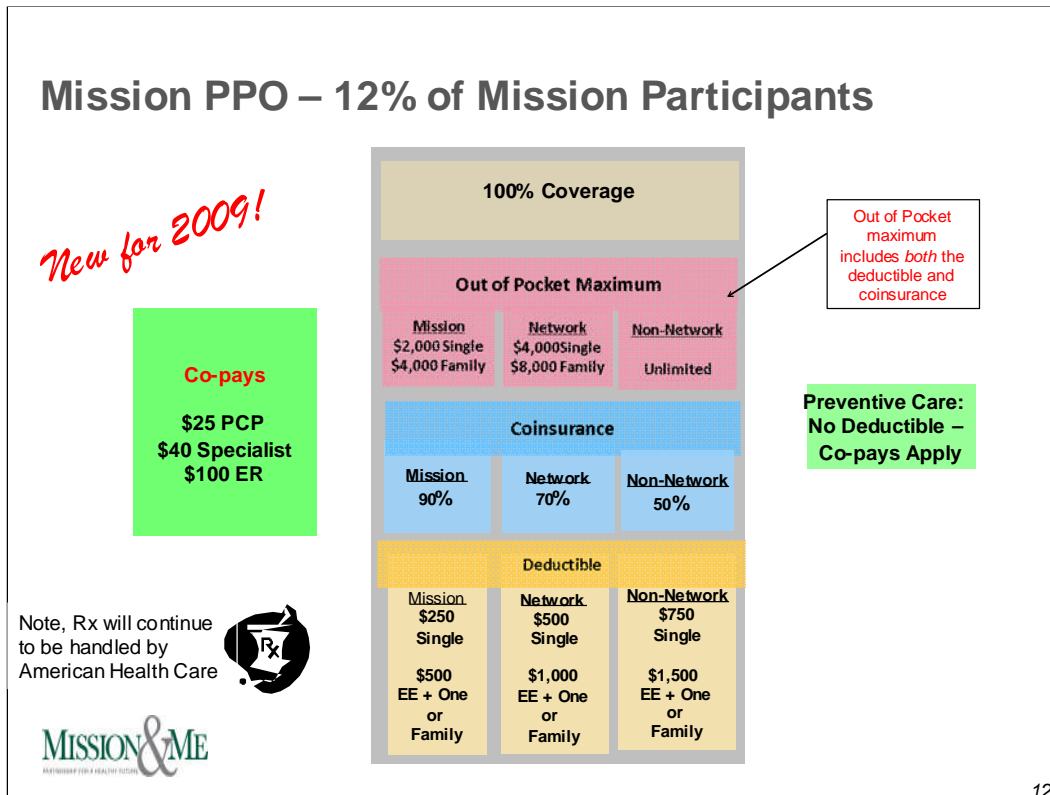
The Mission Basic Plan is a traditional medical plan that has been selected by approximately 1% of the Mission participants (72 employees).

The Mission participant must satisfy the deductible before any Plan benefits will be paid. Once the deductible is satisfied, the Plan will pay 70% of covered expenses while the Mission participant pays the remaining 30%. However, once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of covered expenses.

Prescription drugs are covered under the medical plan, payable at 70% after the deductible.

Although the coinsurance is the same for both in-network and out-of-network services, Mission participants that use a participating network provider will benefit from the negotiated network discounts. Mission participants that use a non-participating provider will be subject to Usual and Customary limits.

Mission PPO – 12% of Mission Participants



The Mission PPO plan is new for 2009 and has been selected by approximately 12% of the Mission participants (656 employees).

Covered Preventive Care, PCP, Specialist and Emergency Room visits are covered at 100% after the applicable co-pay for expenses incurred from a participating provider. If care is received from a non-participating provider, the Plan pays 50% after deductible for covered expenses.

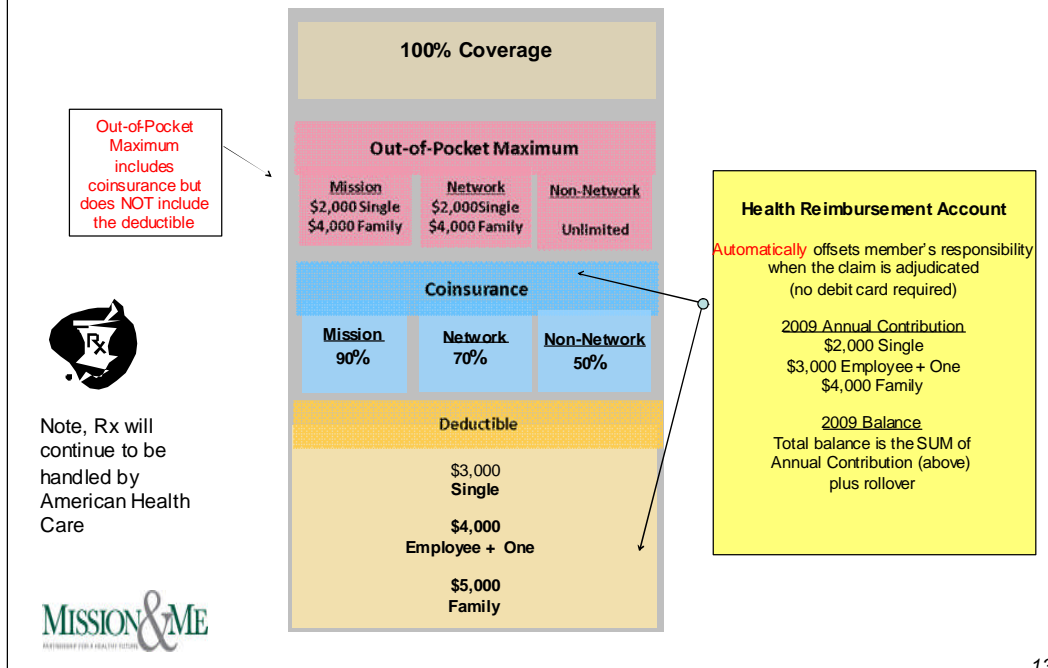
For all other covered expenses, the Mission participant must satisfy the deductible before any Plan benefits will be paid. Once the deductible is satisfied, the Plan will pay 90% of covered expenses incurred at a Mission facility; 70% of covered expenses incurred at all other participating facilities or for participating physician/practitioner services; and, 50% of covered expenses that are incurred from non-participating providers.

Once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of covered expenses. (Except co-pays will always be paid.)

American Health Care will continue as the administrator for prescription drug expenses.

Mission participants that use a participating network provider will benefit from the negotiated network discounts. Mission participants that use a non-participating provider will be subject to Usual and Customary limits.

Mission CDH– 87% of Mission Participants



The majority of Mission participants – 87% in fact – have elected the Mission CDH plan for 2009. (5067 employees)

Covered Preventive Care, if received from a network provider, is paid at 100% with no deductible or co-pay. If care is received from a non-network provider, the Plan pays 50% after deductible for covered expenses.

For all other covered expenses, a deductible and coinsurance apply.

The Mission CDH Plan provides a Health Reimbursement Account (HRA) fund to off-set covered expenses subject to the deductible and coinsurance.

- Until the HRA fund is exhausted, the HRA pays any member responsibility for covered expenses which can include the participant's deductible or coinsurance.
- **Reimbursement is made from the HRA fund automatically when the claim is submitted to CIGNA and processed – no debit card is required. For this reason, we ask that you not collect any member responsibility at the time of service.** If you do require payment from the participant, you may be overpaid if reimbursement is made from the HRA fund and you would need to refund the participant any overpaid amounts.

Once the deductible is satisfied, the Plan will pay:

- 90% of covered expenses incurred at a Mission facility;
- 70% of covered expenses incurred at all other participating facilities or for participating physician/practitioner services; and,
- 50% of covered expenses that are incurred from non-participating providers.

Once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of covered expenses.

American Health Care will continue as the administrator for prescription drug expenses. Rx co-pays do not go toward the deductible.

Mission participants who use a network provider will benefit from the negotiated network discounts. Mission participants that use a non-participating provider will be subject to Usual and Customary limits.

Addressing Patient Financial Responsibility

- **Accessing 2008 HRA Balances in Early 2009**
 - Employees able to demonstrate their 2008 HRA balance via their mybenny.com website information or by calling Wells Fargo TPA
 - No debit card will be utilized -- the BennyCard will be turned off 12/31/2008
- **2009 HRA Balances**
 - Employees able to demonstrate their 2009 HRA balance via their myCIGNA.com website or by calling CIGNA
- **New for 2009 -- CIGNA Auto Claim Forwarding feature**
 - Payment from the HRA goes directly to the provider in the claim adjudication process
 - No debit card will be utilized
- **New CIGNA Feature Planned for 2nd Quarter 2009**
 - Provider access to HRA balance
 - Electronic source for eligibility/benefit information (271 exchange) will include *real time* HRA balance information (Second Quarter, 2009)



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Accessing 2008 HRA Balances (through Wells Fargo)

Note that the BennyCard was turned off December 31, 2008. Participants must file a manual claim for reimbursement from the Wells Fargo HRA until March 31, 2009.

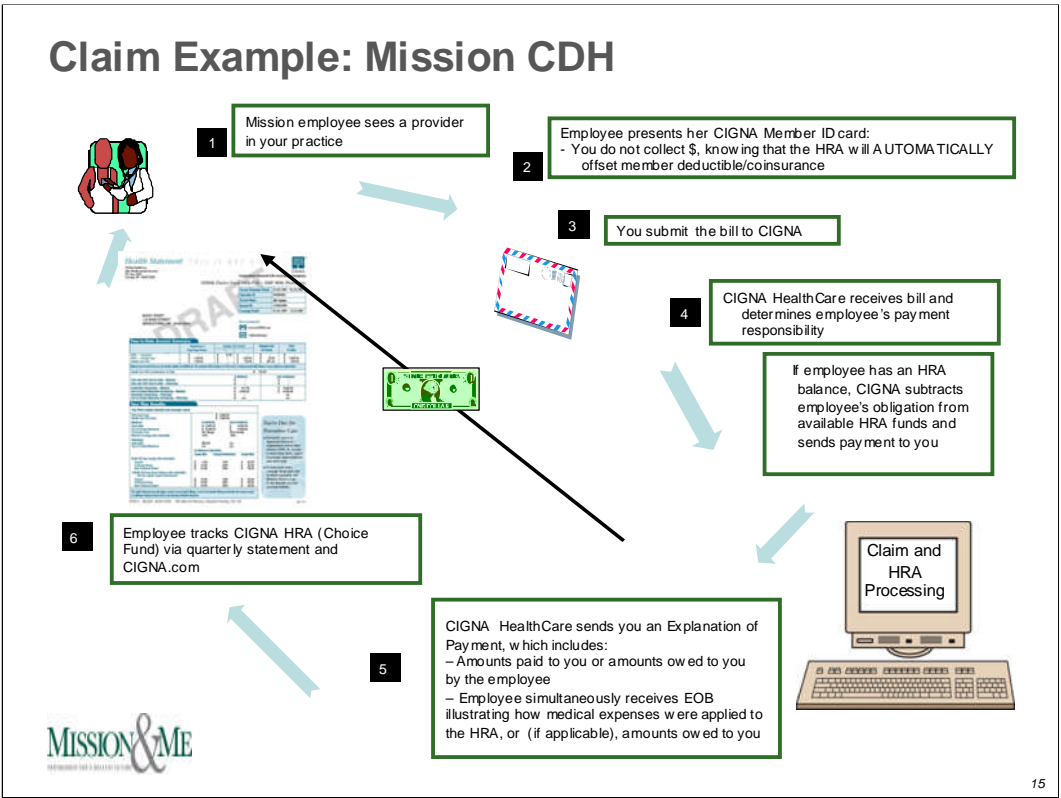
- Employees will NOT be able to use the 2008 HRA for 2008 claim payments after March 31, 2008.
- Employees can demonstrate their 2008 Wells Fargo/Benny Card HRA balance via the mybenny.com website or by calling Wells Fargo TPA.

Accessing 2009 HRA Balances (through CIGNA)

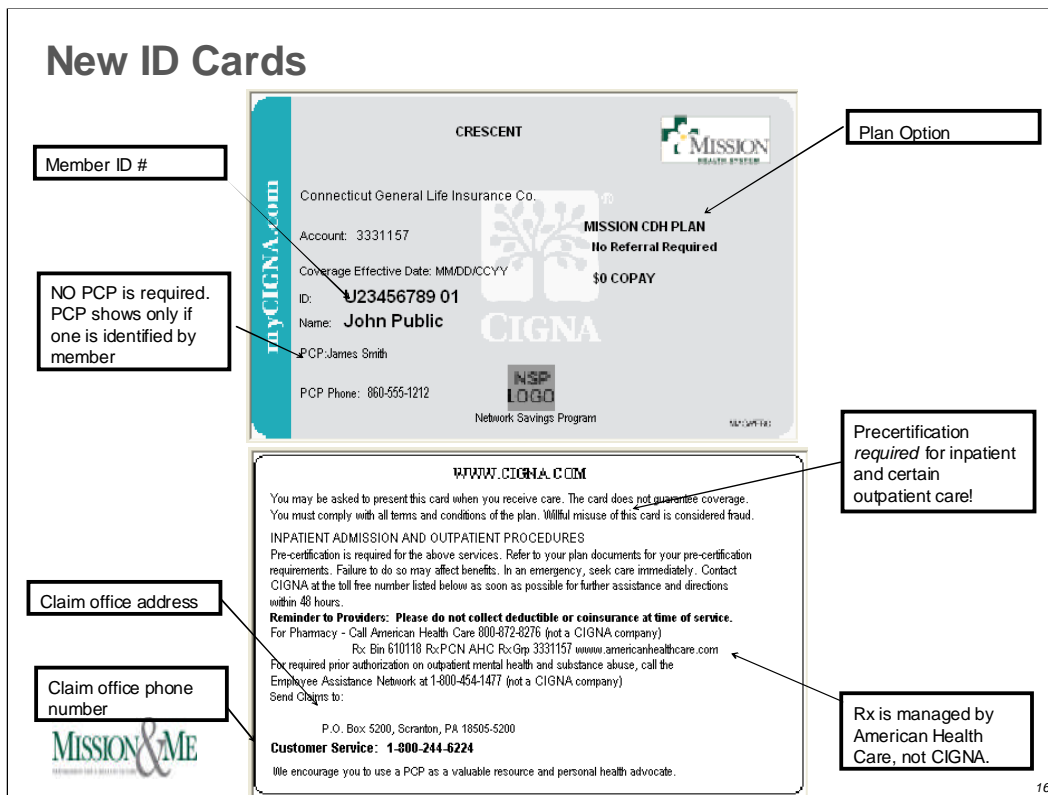
- Any unused 2008 HRA balances will transition to CIGNA after March 31, 2009.
 - 50% of the 2008 HRA balance will transition to the 2009 CIGNA HRA.
 - 50% of the 2008 HRA balance will transition to a special retiree health account.
- Employees can demonstrate their CIGNA HRA balance by going to the employee web site, myCIGNA.com or by calling CIGNA.

• **New for 2009:** CIGNA's Auto Claim Forwarding feature results in payment from the HRA going *directly* to providers if the claim adjudication process results in "member responsibility" (e.g., deductible/coinsurance).

- An enhancement planned for 2nd quarter 2009 will allow providers improved access to HRA balances, including real time balance information!



The workflow above provides an overview of how claim processing will work with CIGNA. Follow the claim flow by reading the slide, starting with number 1 and ending with number 6.



All Mission participants received new ID cards for 2009. The ID card includes information that you need in order to file claims and obtain information.

To protect participants' privacy, CIGNA uses an "alternate member identifier" or "AMI" that begins with "U." However, you may still file claims or make an inquiry using the employees Social Security Number.

In the upper right, the Mission plan is identified – either Mission Basic, Mission PPO or Mission CDH.

Crescent is identified as the plan's network in the middle of the card.

Precertification is required for inpatient and certain outpatient care.

Note that the phone number for the **Employee Assistance Network (EAN)** is included on all cards. **The phone number for American Health Care** (Mission's Pharmacy Benefits Manager) is included on the Mission PPO and Mission CDH cards (prescription drugs are covered under the medical plan for the Mission Basic plan).

The address for submitting claims and the phone number for CIGNA Customer Service is shown on the back of the card.

About CIGNA

CIGNA ranks at the top among health insurers nationwide for paying claims.



Business Insurance



*Readers
Choice
2008*

Business Insurance Magazine has named CIGNA HealthCare as the Best Overall Managed Care Organization in its Readers Choice Awards.

Managed Health Care organization

1. CIGNA HEALTHCARE INC.

CIGNA is the first national health carrier to be recognized by J.D. Power and Associates Certified Call Centers for providing "An Outstanding Customer Service Experience."



For the seventh straight year, CIGNA surpassed the Quality Compass® national average, and the average of our main competitors.



1. For J.D. Power and Associates Certified Call Center Programs information, visit jdpower.com.
2. NCCA 2007 Survey

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CIGNA HealthCare is a national healthcare carrier that has been recognized by many organizations for claims payment, customer service and quality. This is one of the reasons Mission chose CIGNA for its benefit offering in 2009.

CIGNA ranks among the top health insurers nationwide according to the athenahealth PayerView study. Business Insurance Magazine has named CIGNA HealthCare as the Best Overall Managed Care Organization in its Readers Choice Awards. CIGNA is the first national health carrier to be recognized by J.D. Power and Associates Certified Call Centers for providing "An Outstanding Customer Service Experience." For the seventh straight year, CIGNA surpassed the Quality Compass® national average, and the average of our main competitors.

CIGNA Performance

- CIGNA wants to be the provider of choice with providers.
- Our progress in improving the provider experience has received external validation as well
 - Among national payers in 2008 CIGNA ranked #2 overall, and #1 overall in the 2007 report.



2008 results	CIGNA National Level Score	CIGNA Southern Region Score
Days in A/R	33 days	32 days
First Pass Resolve Rate	97%	96%
Denial rate	7%	5%
Claims requiring medical documentation	2%	2%
CCI Non-compliance	1%	1%
Denial transparency	84%	84%
Patient Liability	9%	8%



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CIGNA HealthCare wants to be the provider of choice with providers and has worked hard in improving the provider experience. CIGNA has received external validation for its performance. Among national payers in 2008, CIGNA ranked #2 overall, and #1 overall in the 2007 athenahealthPayerView Performance Study.

athenahealth, Inc. is one of the largest physician billing and revenue-cycle service companies in the U.S. athenahealth, Inc. performs an annual PayerView performance study of major insurance companies including CIGNA, Aetna, Humana, United, Wellpoint/Anthem, Coventry, Medicare B and Champus/Tricare. The study reviews many things including financial performance, administrative performance, medical policy complexity and more. CIGNA's strong performance in the athenahealth PayerView study demonstrates that we continually strive to improve service and our commitment to our Provider Value Proposition, specifically to shorten provider revenue cycles, minimize administrative costs and reduce the complexity of doing business with CIGNA. athenahealth, Inc. issued its third annual PayerView benchmarking ratings of regional and national carriers' claims payment timeliness and accuracy. Nationally, CIGNA continues to be among the leaders in the PayerView rankings. Among national payers in 2008 CIGNA ranked #2 overall, and #1 overall in the 2007 report. We also achieved the number one ranking this year for the Claims First Pass Resolve Rate metric which speaks to providers wanting to be paid right the first time.

The PayerView study also broke-out the results by region. CIGNA had a strong performance in the South Region which includes North Carolina and South Carolina. CIGNA's overall index rating in the South Region **outperformed** BC/BS of North Carolina, BCBS of South Carolina, United, Aetna, Humana, Medicare, Medicaid, and Champus/Tricare. CIGNA outperformed all payers in the South Region on claim denial rate and first pass resolve rate (including BCBS, Aetna, United, and Humana). CIGNA scores in the South were slightly higher than the CIGNA scores rolled-up at the national level

CIGNA Experience

- Health plan membership of 10 million Americans
- CDHP membership exceeding 840,000
- NC/SC Membership 627,578



- **Tennessee, North and South Carolina Key CDH Clients**

- Hanesbrands Inc.
- Carlisle Companies
- Kerr Drug
- Mitsubishi Polyester Film
- Coca-Cola Consolidated Bottling Company
- Eastman Chemical



- **Hospital System Clients**

- LSU University and Hospital Systems
- Greenville Hospital System
- Novant Health



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CIGNA's Consumer Directed Health Plan (CDHP) membership exceeding 840,000 in America. Over 450 Customers offer CDHP plans. 40% offer HRA; 55% offer HSA; 5% offer both. Membership - 82% HRA, 18% HSA
95%+ re-enrollment rate

There are approximately 627,578 CIGNA members in North and South Carolina. Some of CIGNA's accounts include Hanesbrands Inc., Carlisle Companies, Kerr Drug, Mitsubishi Polyester Film, Coca-Cola Consolidated Bottling Company and Eastman Chemical.

Some of CIGNA's hospital system clients include: LSU University and Hospital Systems, Greenville Hospital System and Novant Health.

Working With CIGNA – Precertification Key Facts

Mission Hospital has the Personal Health SolutionsSM Plus (PHS+) Precertification Model:

Requires Precertification for:

- Inpatient hospital care / Inpatient Rehabilitation
- Skilled nursing facilities / Long-term care facilities
- Certain outpatient services, which can be found on www.cignaforhcp.com

Continued stay review/inpatient case management begins on the first day of admission

A complete list of procedures requiring precertification can be found on our website – www.cignaforhcp.com



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Effective 1.01.09, Mission employees will have **CIGNA's Personal Health Solutions Plus (PHS+) precertification model** with CIGNA.

- This means that inpatient services and selected outpatient services require prior approval from CIGNA in order for them to be covered.
- The inpatient services that require precertification from CIGNA include inpatient hospital care, inpatient rehabilitation, skilled nursing facilities and long term care facilities.
- A list of the outpatient services that require precertification can be found on CIGNA's website at **www.cignaforhcp.com**.
- Providers can complete their precertification request through CIGNA's website at www.cignaforhcp.com.

Working With CIGNA – Precertification During Transition

To facilitate a smooth transition, CIGNA and WFTPA are working together to transfer precertifications on file for dates of service between January 1st and January 16th

- Any precertification request processed by WFTPA prior to January 1st for dates of service between January 1st and January 16th will be honored by CIGNA
- We will receive the first file of authorizations by December 17th with a subsequent file by December 31st
- We will also receive faxed copies of the authorizations to be imaged
- We will update our systems with the information

There will be no additional review necessary for these previously reviewed precertifications



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Precertification requests processed by Wells Fargo prior to January 1st for dates of service between January 1st and January 16th were honored by CIGNA.

- There is no additional review necessary for these previously approved precertification requests.

Working With CIGNA – Transplant Network



A network of transplant facilities and support services for individuals facing a transplant. We help ensure quality and service through:

- A team of dedicated nurse transplant case managers
- National quality programs and credentialing
- Clinical Resource Tools - clinical guidelines developed and maintained by CIGNA HealthCare medical management and based on peer reviewed literature

cignallifesource.com is an effective resource for helping your patients manage the complicated transplant process

Phone: 1.800.668.9682 for CIGNA HealthCare members and health care professionals

E-mail: lifesourceweb@CIGNA.com

Please contact CIGNA LifeSOURCE about any patient actively receiving transplant services other than routine follow-up care



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Effective 1.01.09, Mission employees will use CIGNA's Lifesource transplant program and network. Lifesource is a network of transplant facilities and support services for individuals facing a transplant. Lifesource helps ensure quality and service through:

- A team of dedicated nurse transplant case managers,
- National quality programs and credentialing,
- Clinical Resource Tools - clinical guidelines developed and maintained by CIGNA HealthCare medical management and based on peer reviewed literature.

The Lifesource website (cignallifesource.com) is an effective resource for helping patients and providers manage transplants.

Call Lifesource at 1.800.668.9682 or email them at lifesourceweb@cigna.com to discuss any patients that have had previous transplants or are planning transplants in 2009.

Lifesource will help facilitate all transplant services for your Mission patients.

Working With CIGNA – Electronic Claim Solutions

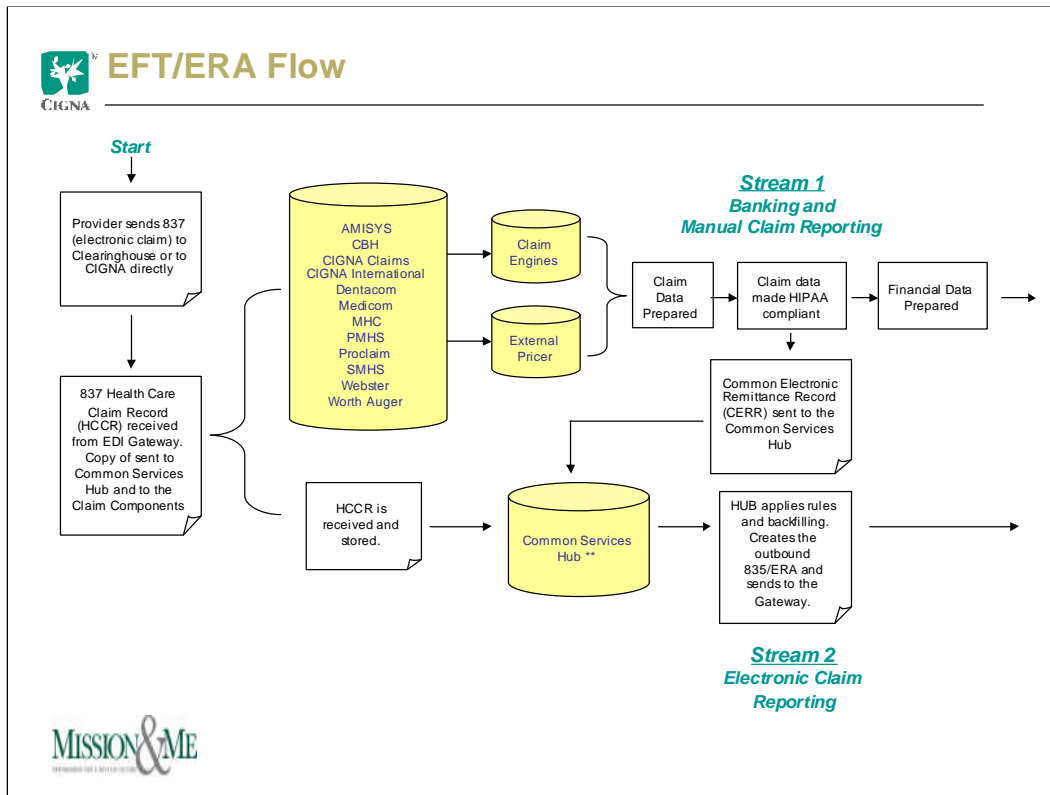
- **Clearinghouse acts as a liaison between you and CIGNA HealthCare when submitting claims electronically**
 - Contact Emdeon @ www.emdeon.com or 1.877.469.3263
 - Single payer IDs for easy claims submission: CIGNA HealthCare = 62308
- **Post-N-Track allows you to submit claims directly to CIGNA**
 - Enrollment and information at www.post-n-track.com
 - Will accept any number of claims at no additional cost to you
 - Claims are immediately delivered to CIGNA
 - Secure and HIPAA-compliant process
- **Electronic Funds Transfer (EFT) / Direct Deposit**
 - Improves cash flow & avoids mailing delays
 - Registration information and forms available at www.cigna.com
- **Direct Deposit Activity Report**
 - Contains details of the claims processed in the EFT
 - Separate report for each EFT



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Using electronic services saves providers time and money. CIGNA offers a full suite of electronic solutions listed above.

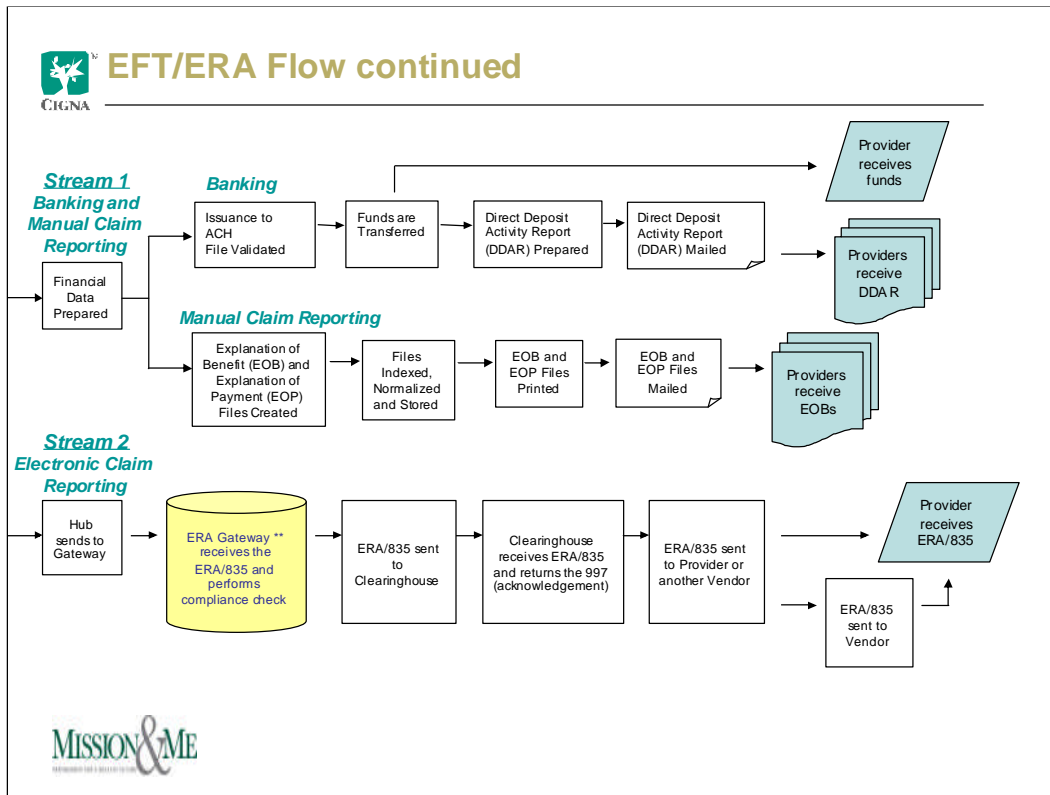
Visit CIGNA's website (www.cignaforhcp.com) or contact CIGNA HealthCare Provider Services (1.800.88CIGNA) to find out more about or to register for these services.



Filing claims electronically, receiving payments electronically and receiving electronic remittance advices saves you time and money.

The chart above outlines the flow of a claim with electronic funds transfer and electronic remittance advices.

Please contact CIGNA HealthCare Provider Services **(800.88CIGNA)** or visit our **website (www.cignaforhcp.com)** to begin using these services.



More information on how a claim with electronic funds transfer and electronic remittance advice flows.

Working With CIGNA – Claim Processing Solutions

- Payment and Modifier Policies - Available Online
- CIGNA has developed a standardized approach to modifier application based on guidelines from the Centers for Medicare and Medicaid Services and the American Medical Association.
 - CIGNA HealthCare modifier policy based on Medicare and AMA guidelines
 - Providers will no longer be required to submit paper documentation when using modifiers
 - Improved reimbursement for more intensive interactions (i.e., multiple births, preventive visits)
 - Ease of administration
 - All policies are posted on CIGNA for HealthCare Professionals website

The modifier and reimbursement policies are located on www.cignaforhcp.com under Resources>Secure Information>Look Up Information About>Modifier Link



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Providers have asked how CIGNA handles claims processing and modifier payment. CIGNA has developed a standardized approach to modifier application based on guidelines from the Centers for Medicare and Medicaid Services and the American Medical Association.

Providers will no longer be required to submit paper documentation when using modifiers for improved reimbursement for more intensive interactions (i.e., multiple births, preventive visits, etc.)

The modifier and reimbursement policies are located on **www.cignaforhcp.com under Resources>Secure Information>Look Up Information About>Modifier Link.**

Working With CIGNA – Standardized and Updated Approach to Modifiers

Changes made to policies for standard modifiers

- Reduced hassle for providers
- Increased efficiency, and more effective electronic claim adjudication/payment

May 2007

- Modifiers – 26, 47, 50, 51, 80, 82, 90, QX, QY, SG, 21, 23, 32, 74, 76, 77, 91
- Documentation requirement lifted

June 2007

- Modifiers – 22, 27, 62, 63, 66, 81, 99, AS
- Documentation requirement lifted

July 2007

- Multiple Births – When submitted with modifiers, CIGNA will reimburse separately
- Documentation requirement lifted

August 2007

- Modifiers 24, 25, 52, 53, 54, 55, 56, 57, 58, 59, 73, 78, 79, QZ, SA, SB, TC
- Documentation requirement lifted, reimbursement changes



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In 2007, CIGNA updated reimbursement policies for standard modifiers. These changes were intended to provide a more standardized approach based on guidelines from CMS and the AMA CPT Manual. Prior to the changes, CIGNA pended or denied claims and asked for office notes, medical records, etc., which was an administrative burden for providers. Statistics revealed that CIGNA, like providers, also spent a large amount of time on the re-work and more often than not, reprocessed the claim to pay additional funds.

The end result of these changes? First-pass processing for the service and quicker reimbursement for services rendered.

May 2007 - Modifiers – 26,47,50,51,80,82,90,QX,QY,SG,21,23,32,74,76,77,91
Documentation requirement lifted

June 2007 - Modifiers – 22, 27, 62,63,66,81,99,AS
Documentation requirement lifted, reimbursement changes

July 2007 - Multiple Births – When submitted with modifiers, CIGNA will reimburse separately

August 2007 - Modifiers 24,25,52,53,54,55,56,57,58,59,73,78,79,QZ,SA,SB,TC
Documentation requirement lifted, reimbursement changes

This change in CIGNA's modifier policy improved appeal responsiveness and consistency.

Working With CIGNA – Appeal/Timely Filing

■ Provider Dispute Resolution/Appeals

CIGNA Provider Claims Appeals

P.O. Box 5225

Scranton, PA 18505-5225

Two-level appeal process* to resolve disputes:

First level must be initiated within 180 calendar days of the date of initial payment or denial decision

Second level must be initiated within 60 calendar days of the date of on the first level decision letter

Additional details for filing are posted on www.cignaforhcp.com

■ Timely Filing Requirement

CIGNA's standard timely filing requirement for CIGNA HealthCare is 180 days, however, timely filing requirements can vary by contract. CIGNA's systems will honor the timely filing requirement in the contract.



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If a provider needs to appeal a claim, they can do so in writing using the address above. There are two levels of appeal:

- First level must be initiated within 180 calendar days of the date of initial payment or denial decision
- Second level must be initiated within 60 calendar days of the date of on the first level decision letter

Additional details for filing are posted on www.cignaforhcp.com.

CIGNA's standard timely filing requirement for CIGNA HealthCare is 180 days, however, timely filing requirements can vary by contract.

CIGNA's systems will honor the timely filing requirement in the employer's contract.

Working With CIGNA – www.cignaforhcp.com

CIGNA for Health Care Professionals is our secured website

- Convenient, easy access to information and transactions
- Delegate access to office staff
- Multiple user capability
- Link to Mission members' eligibility and benefits

Additional information available:

- | | |
|---------------------------------------|---------------------------------|
| → Eligibility and benefit information | → Procedure code bundling edits |
| → Forms | → Claim requirements |
| → Provider reference guides | → Claim status and details |
| → Coverage positions | → Benefit plan descriptions |
| → Claim appeals policy | → Precertification requests |



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The CIGNA for Health Care Professionals website is a secure site just for health care providers. It offers convenient, easy access to information and transactions for your Mission patients. It's also your place to go for general information that's important for your practice and your relationship with CIGNA. You must be a registered user to access the site. Registration is quick and easy. The website address is www.cignaforhcp.com. On the website, you can find the following and much more: eligibility, benefits, forms, CIGNA's Provider Reference Guide, coverage positions, claims appeals information, procedure code bundling edits, claim requirements, claim status, precertification and more. You can view a demonstration of the website as well.

Working With CIGNA – On-Line Precertification

- Determine if precertification is required
- Submit a precertification request
- Inquire about a previous precertification request
 - You will immediately see a response of whether a request is approved or pended for review
 - In fact, 85% of online precertification requests will “auto-certify”
 - If additional information is needed, a call is made to the provider within 48 hours
- Two ways to access:
 - CIGNA for Health Care Professionals website (www.cignaforhcp.com)
 - NaviNet® for CIGNA website (<https://navinet.navimedix.com>)
NaviNet is an easy-to-use, multi-payer website that gives you access to member and plan information for your patients covered under a variety of health plans, including CIGNA HealthCare



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The actuarial firm Milliman recently performed a study to estimate providers' costs for dealing with precertification. The study indicates that providers' costs for manual precertification (by calling CIGNA HealthCare and faxing the clinical information) costs providers approximately \$10.87 per transaction. Utilizing on-line precertification costs approximately \$2.07 per transaction.

So, doing precertifications on-line saves providers \$8.71 per transaction.

CIGNA's website (www.cignaforhcp.com) offers on-line precertification. At the website, you can determine if precertification is required, submit a precertification request and inquire about a previous precertification request.

Providers will *immediately* see a response of whether a request is approved or pended for review. 85% of online precertifications requested will auto-certify. If additional information is needed, a call is made to the provider within 48 hours.

Providers can access the precertification function on the CIGNA website (www.cignaforhcp.com) or via NaviNet (<https://navinet.navimedix.com>).

Where to Go/Who to Call – Provider Checklist

Wells Fargo TPA for services incurred through December 31, 2008:

Mailing Address:
 WFTPA
 PO Box 3262
 Charleston, WV 25332

Telephonic Inquiries:
 1-800-847-2770

Toll-Free Fax:
 1-866-662-6135

Reminder: For services incurred prior to 1/1/2009, send your claims to Wells Fargo TPA

CIGNA HealthCare for services on/after January 1, 2009:

Website (www.cignaforhcp.com)
 for real-time information

- Claims
- Benefits
- Precertification
- Policies and Procedures and more!

Mailing Address:
 CIGNA
 PO Box 5200
 Scranton, PA 18505-5200

Telephonic Inquiries:
 1-800-88CIGNA (800-882-4462)

Crescent Preferred Provider Organization

Deana Gardner
 Provider Relations
 1200 Ridgefield Blvd., Ste. 215
 Asheville, NC 28806
 Telephone: (828) 670-9145 or (800) 707-7726
 x/110
 Fax: (828) 670-9155
deana.gardner@crescentppo.com



EAN Employee Assistance Network

Dawn M. Klug, MS/LPC
 Clinical Supervisor and Senior Account Manager

Employee Assistance Network
 Doctor's Park, Suite 3-C
 417 Biltmore Avenue
 (828) 252-5725 or 1-800-454-1477
dawn@eannc.com



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We want to make sure providers have the correct contact information to make sure that Mission's transition from Wells Fargo to CIGNA goes smoothly.

Above is a provider checklist contains appropriate contact information to show providers where they can go to get the support they need.

RECAP: Our Strategic Goals

- **Significantly improve plan administration and service to employees and providers**
- **Engage our people in a meaningful and sustained way**
- **Make measurable contributions to improving staff health and wellness**
- **Complement internal disease management programs**
- **Re-brand and re-communicate a total health management program**
- **Manage total cost at the most efficient level possible while supporting a highly competitive health plan**



Thank You!

E A N
employee assistance network



A Collaborative Approach to Regional Healthcare

Directly-
contracted
providers

MISSION & ME *& you!*
PARTNERSHIP FOR A HEALTHY FUTURE

*We appreciate you and look forward to working with you in 2009 –
and so do our employees!*

