

SECTION 6 CIGNA Products





CIGNA's menu of services includes the provision of mental health and substance abuse services to CIGNA HealthCare, including its HMOs, PPO, and Point-of-Service programs. In addition, CIGNA provides behavioral care services, management, and Employee Assistance to many other HMOs and employers nationwide.

CIGNA Services to CIGNA HealthCare, Other HMOs and Stand-Alone National Accounts

Health Maintenance Organizations (HMO)

CIGNA manages the mental health and substance abuse benefits for CIGNA HealthCare as well as other HMOs. CIGNA's Regional Care Centers (RCC) manage intake, verify eligibility and benefits, and provide treatment authorization and Care Management. Some HMO products also include an out-of-network option. Claims are processed at the CIGNA Claims department in Minnesota.

CIGNA Preferred Provider Organizations (PPO)

In CIGNA's PPO open access product, participants may select any CIGNA practitioner listed in a network Provider Directory. Benefits, coinsurance, and claim information are listed on the participant's ID card. CIGNA does not pay claims for this product.

Stand-Alone Employer Accounts

Some employers contract with CIGNA to manage their behavioral benefits as a 'carve-out' from their general medical coverage. CIGNA's National Care Center (NCC) and, on occasion, a Regional Care Center, manage intake, verify eligibility and benefits, and provide treatment authorization and Care Management. CIGNA's Claims department or a Third Party Administrator (TPA) process the claims.

Medicare

In accordance with federal laws, the information under this section complements the CIGNA Participating Provider Agreement.

Medicare Managed Care

CIGNA practitioners deliver services to Medicare participants enrolled in an HMO Benefit Agreement with Medicare Advantage organizations. The benefits supplied by Medicare Advantage organizations are a *Medicare replacement product*, rather than a Medicare supplemental plan. A participant has to be enrolled in Medicare and opt to have coverage by a Medicare Advantage organization. Medicare participants are identified by their membership card.

Access to Records and Facilities

CIGNA's contracted practitioners and downstream entities must allow CIGNA HealthCare, U.S. Department of Health and Human Services, the Comptroller General, or their designees to audit, evaluate, or inspect any books, agreements, medical records, participant care documentation, and any other additional relevant information that the Centers for Medicare & Medicaid Services (CMS) may require which pertains to any aspect of services rendered to Medicare participants. All records and documents must be maintained for a period of six years. Contracted practitioners and downstream entities must also make available their premises, physical facilities and equipment for the purposes described above.



Confidentiality and Accuracy of Participant Records

CIGNA's contracted practitioners must safeguard the privacy of any information that identifies a particular participant. Information from, or copies of, records may be released only to authorized individuals. Practitioners must abide by all Federal and State laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and participant information. Original medical records must only be released in accordance with Federal or State laws, court orders, or subpoenas.

CIGNA's contracted practitioners must also maintain participant records and information in an accurate and timely manner.

Transfer of Medical Records

All CIGNA contracted practitioners (practitioners and institutional practitioners) must have authorization/release forms and a policy for the transfer of Medical Records. Medical Records are to be transferred within five to ten working days of receiving a request from a Medicare participant or the participant's legal representative. If the transfer cannot be accomplished within that time period, the participant should be informed by telephone of the reason for the delay, and the date and time of the call should be documented. Requests for release of any medical information must include a signed release by the participant or legal representative, and the request must be no more than twelve months old or other time period as may be specified by State laws. Medical records are to be packaged and transferred in a manner that protects the privacy of the record in transit.

Expedited requests for the transfer of medical records must be processed in a timely manner that does not interfere or cause delay in the provision of services to the CIGNA participant.

Emergency requests refer to instances where another health care practitioner requires past medical/ surgical history on a CIGNA participant to maintain continuity of care. The request should be verified by calling the practitioner back. After verification, medical information may be read over the telephone or faxed to the appropriate location. A notation should be made in the participant's record indicating the information released, and to whom it was released. When possible, a release should be sent to the receiving practitioner to be completed, signed by the participant, and returned to the medical record.

Serving a Diverse Population

No Discrimination Allowed

CIGNA contracted practitioners cannot differentiate or discriminate in the treatment of any Medicare Advantage participant on the basis of health status, race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, handicap or source of payment.

Providing Services in a Culturally Competent Manner

All services to CIGNA's Medicare participants must be provided and administered in a culturally competent manner; including those services to participants with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities.



Please contact CIGNA (telephone number located on the participant's ID card) if information or assistance is needed in administering services in the following areas:

- Plan and community support services for 'culturally diverse' participants, including participants with diverse cultural and ethnic backgrounds and the homeless.
- Translator or translation services for non-English speaking participants to meet specific language needs during treatment.
- Availability of health information brochures for participants in various languages.
- Hearing impaired assistance through a relay service.
- Assistance for the visually impaired.

Access must be provided for the physically handicapped. CIGNA will continue to assess this access during practitioner site reviews and as part of the credentialing and recredentialing process.

Complex Care, Follow-Up Care and Self-Care

CIGNA arranges/seeks participant approval to exchange information (including results of health assessments completed in the first 90 days of enrollment) between Medicare Advantage health plans and primary care physicians. This information will be used for early identification and coordination of care of participants with complex or serious behavioral health conditions.

CIGNA's contracted practitioners must ensure that Medicare participants are informed of specific health care needs that require follow up and that they receive, as appropriate, training in self-care and other measures they may take to promote their own health.

Claims and Encounter Reporting

Reporting of Encounter Data

CIGNA's contracted practitioners who are required to submit encounter data for Medicare must certify that the submitted encounter data is accurate, complete, and truthful to the best of their knowledge. CIGNA in turn will submit this information to CMS. The encounter data must include all data necessary to characterize the content and purpose of each encounter between a Medicare participant and a contracted practitioner or entity.

Claims Processing

Medicare has regulations regarding the timely payment of all claims. In accordance with CMS requirements, CIGNA will ensure that all non-participating practitioners' claims are paid within thirty calendar days following receipt of a clean claim and all other claims paid within sixty (60) calendar days. To assure compliance with claims payment regulations, CIGNA submits monthly, quarterly, and annual claim payment reports to Medicare Advantage health plans.



Appeals and Grievance Process

Organization Determinations and Standard Appeals

CIGNA and its delegated practitioners must make an Organization Determination to provide, authorize, deny, or discontinue a Medicare service as expeditiously as the participant's health condition requires (but no later than fourteen calendar days for a standard request, seventy-two hours for an expedited request, or within sixty (60) calendar days for a payment of service request).

If CIGNA's decision is unfavorable, (also called Adverse Organization Determination), the denial must be in writing. If unfavorable, the participant may appeal to the contracted health plan for reconsideration. The maximum time frame for Care Management decisions is now reckoned in 'calendar days', as opposed to 'working days'. CIGNA may extend the time frame by up to fourteen calendar days if CIGNA justifies the need for additional information, including how the delay is in the interest of the enrollee, or if the participant requests an extension.

The reconsideration procedure applies to all benefits offered in Medicare Advantages' benefit packages, including mandatory supplemental benefits, and optional additional benefits.

If a participant requests reconsideration, a decision is made by the Medicare Advantage health plan based on a review of the initial determination and any newly available information. If Medicare Advantage health plan recommends a partial or complete affirmation of CIGNA's initial organization determination, the entire case file is forwarded to the Center for Health Dispute Resolution (CHDR), a CMS contractor. If the Medicare Advantage health plan's decision is partially or fully upheld by CHDR, the participant may have their appeal reviewed by an Administrative Law Judge, if the claim/service that is the object of the appeal is at least \$100. If the Administrative Law Judge fully or partially upholds the Medicare Advantage health plan's decision, the participant may request a review by the Medicare Appeals Council of the Social Security Office. If the Medicare Appeals Council denies the request for review, or if it makes a decision which was the final decision of the Secretary, and the amount in controversy is \$1,050 or more, a civil action may be filed in a District Court of the United States.

Practitioner Appeals on Behalf of Participants

Practitioners may appeal on behalf of Medicare participants. CMS requires that practitioners be an enrollee's 'authorized representative' in order for the practitioner to request an appeal on the enrollee's behalf. An 'authorized representative' is an individual who receives written authorization by an enrollee to act on his or her behalf in obtaining an organization determination, or in dealing with any level of the appeal process.

Non-participating practitioners may appeal on their own behalf and not as an authorized representative. If the non-participating practitioner appeals, he/she must complete and sign the waiver of liability payment form. The health plan coordinator will work with the practitioner to complete this form.



Appeal of Hospital Inpatient Care Denial (NODMAR)

According to federal law, the participant's discharge date must be determined solely by medical needs and not by any method of payment. Participants have the right to be fully informed about decisions affecting their coverage and payment for their hospital stay and for any post-hospital services.

Participants have the right to request an immediate review by a Quality Improvement Organization (QIO) prior to being discharged from hospital care, if the participant disagrees with the attending physician's decision to discharge. CIGNA will issue a Notice of Discharge and Medicare Appeal Rights (NODMAR) to the participant through the contracted facility staff. The NODMAR notice provides instructions on how to request a QIO review and the applicable time frames.

Grievance Process

CIGNA has established an internal grievance process for receiving and resolving participants' complaints and/or grievances concerning participating practitioners, physicians, or staff. The first step for all grievances is for the participant to speak directly with the practitioner or supervisor in the practitioner's office in which the incident occurred. If the Medicare participant does not feel the matter has been satisfactorily resolved or chooses not to contact the practitioner, he/she may call the CIGNA's Customer Service representative or number on participant's ID card.

When CIGNA cannot resolve a complaint/grievance to the participant's satisfaction, it must forward the grievance to the health plan's Medicare Grievance Coordinator within five calendar days from the date the complaint was first received by CIGNA. The Grievance Coordinator will work with the participant to resolve the grievance within thirty calendar days from the date the complaint was first received by CIGNA. If the Medicare participant does not feel the Medicare Grievance Coordinator has satisfactorily resolved the matter, he/she has the right to formal resolution through the health plan's Medicare Grievance Committee. The participant initiates the formal grievance process by making a written request for a hearing before the Medicare Advantage health plan's Grievance Committee. A hearing before the committee will be scheduled within thirty (30) calendar days of the receipt of the written request for a formal grievance. Upon consideration of the facts presented by the participant in writing, the Grievance Committee will render a decision within fourteen calendar days of the Grievance Committee meeting. The participant will be notified in writing of the Grievance Committee's decision, which shall be the final administrative review of the matter.

Advance Directives

In accordance with the Patient Self-Determination Act, Medicare managed care plans and participating practitioners are required to ensure that: 1) participants are informed of their rights with respect to advance directives, and 2) documentation regarding execution of Advance Directives is maintained in the medical record.

An advance directive is a written statement completed in advance of serious illness. The statement indicates what kind of medical treatment a participant does or does not want under special serious medical conditions should they become mentally or physically unable to communicate their wishes. The two most common forms of advance directives are Living Will and Durable Power of Attorney.



The Role of the Physician Practitioner

CIGNA requires all practitioners to make a notation in the participant's medical record as to whether or not the participant has completed an Advance Directive. When an Advance Directive exists, a copy should be placed in the medical record. As long as he/she is of sound mind, the participant may complete an Advance Directive form and may revoke it at any time.

Under the law, a participant has the right to refuse medical treatment and to have his/her Advance Directives complied with. If a practitioner cannot in good conscience follow those directives, he/she must contact CIGNA's Provider Relations department. CIGNA will then assist the participant in selecting a physician who can comply with these directives.

Neither CIGNA nor its individual practitioners may condition the provision of care or otherwise discriminate against a participant based on whether or not the participant has executed an advance directive.

Access to Services

All services covered by Medicare must be provided in a manner consistent with professionally recognized standards of health care. CIGNA participating practitioners must provide, on a twenty-four hour per day, seven days per week basis, necessary covered services to Medicare participants or arrange for a covering practitioner. A practitioner must ensure that the covering practitioner satisfies CIGNA's credentialing criteria, and that the covering practitioner will not seek to obtain reimbursement for which the practitioner already receives reimbursement from CIGNA.

Emergency

CMS has established new definitions for emergency and urgently needed services, codifying the concept that an 'emergency medical condition' exists if a 'prudent layperson' could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm to the individual. The new definition of 'emergency services' includes emergency services provided both within and outside of the plan.

Urgently Needed

'Urgently needed services' encompass only services provided outside of the plan's service area (or continuation area, if applicable) except in extraordinary circumstances. Specifically, these regulations allow for coverage of non-emergency services where the services are immediately required because of unforeseen illness, injury or condition, and it is not reasonable given the circumstances to obtain the services through the network of participating practitioners.

Post-Stabilization

The regulations allow for CIGNA to assume financial liability for post-stabilization care.

'Post-stabilization' care means medically necessary, non-emergency services needed to ensure that the enrollee remains stabilized from the time that the treating hospital requests authorization from CIGNA until:

- The enrollee is discharged;
- A CIGNA practitioner arrives and assumes responsibility for the enrollee's care; or
- The treating practitioner and CIGNA agree to another arrangement.



The decision of the examining practitioner treating the individual participant prevails regarding when the participant may be considered stabilized for discharge or transfer.

CIGNA is responsible for the cost of post-stabilization care provided by practitioners outside the plan when CIGNA does not respond to a preapproval request by the practitioner within one hour after the request was initiated, or if CIGNA could not be contacted for preapproval. CIGNA's liability will extend until the hospital is contacted to arrange for discharge or transfer of the participant.

Plan Benefits

Medicare Advantage Medicare participants receive the full range of Medicare services plus additional benefits that are not covered by Medicare; for example, prescription drugs and routine care may be included. Please check with CIGNA's care center for additional benefits applicable to individual participants. Participants can access mental health and substance abuse services directly through CIGNA. They do not require a referral from their Primary Care Physician.

Many Medicare Advantage organizations such as CIGNA HealthCare offer extra benefit riders or special additional benefits for employer sponsored retiree groups. Since it is extremely important that each participant receive all the benefits and supplies he/she is entitled to, we encourage practitioners to get acquainted with the various CIGNA benefit options in your area and check specific coverage details on every participant.

The following are the standard benefits that must be offered all Medicare Advantage participants.

Outpatient Mental Health Services:

- Mental health follow-up diagnostic services.
- Mental health therapeutic office services.
- Mental health hospital day treatment.
- Alcohol and substance abuse day treatment program.

Inpatient Mental Health Services:

- Lifetime maximum of one hundred ninety days of care provided in a Medicare-approved psychiatric hospital or licensed psychiatric ward for mental illness and substance abuse combined.

Participant Billing

Practitioners must hold Medicare Advantage participants harmless for payment of fees that are the legal obligation of the Medicare Advantage organization to fulfill. Such provision will apply, but not be limited to insolvency of the Medicare Advantage organization, contract breach, and practitioner billing. Under no circumstances is a Medicare Advantage participant to be balance billed for care, service, or supplies. If the practitioner uses an automatic billing system, bills must clearly state that they have been filed with the insurer and that the participant is not liable for payment other than applicable copayments.



Should a Medicare Advantage participant elect to have care or service provided that is not a covered benefit or which have been determined *prior* to providing the service to not be medically necessary or any other reason, the practitioner must have written agreement of financial responsibility from the participant including the exact dollar amount. This agreement must be signed in *advance* of service delivery and be added to the permanent medical record of the participant. It is the practitioner's responsibility, not the participant, to determine coverage parameters in advance of providing the medical service.

Practitioner Termination/Status Change Notification

CIGNA and its participating practitioners must accept all Medicare Advantage participants who select them unless the health plan is notified in advance that the practitioner cannot accept additional participants. Practitioners must give 60 days notice of termination and thirty days notice of significant access changes (i.e., vacations).

Practitioner shall immediately notify CIGNA of any change in practitioner's licensure and/or certifications that are required under federal, state, or local laws for the provision of Covered Services to Medicare participants, or change in practitioner's hospital privileges, whether at a CIGNA participating facility or non-participating facility.

In the event that CIGNA has cause to terminate the agreement of a participating practitioner that provides services to Medicare participants, CIGNA will issue the practitioner a written notice. The notice will include, to the extent that it is relevant to the decision: (1) the reason for termination, (2) the standards and the profiling data used to evaluate the practitioner, (3) the numbers and mix of practitioners required in its network, and (4) the terminated practitioner's right to appeal the action and the process and timing for requesting a hearing.

If either party terminates a participating provider's agreement, CIGNA will notify all Medicare participants that are seen on a regular basis by that practitioner. The written notification will be made to affected participants within fifteen working days of receipt or issuance of a notice of termination.

Excluded Practitioners

In accordance with 42 CFR 422.752, CIGNA and its downstream practitioners are barred from employing or contracting with individuals who are excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act, or with an entity that employs or contracts with such individuals for the provision of any of the following:

- Health care
- Utilization review
- Medical social work
- Administrative services

Individuals or entities found to be in violation of this regulation may be subject to sanctions and civil money penalties including, but not limited to, fines ranging from \$10,000 to \$100,000, suspension of enrollment of Medicare beneficiaries, and suspension of payments.



Insurance

Practitioners must obtain comprehensive general liability, professional liability, workers' compensation and other insurance, in amounts determined by CIGNA, based on the practitioner's mode of practice/specialty, to insure against any claim(s) for damages resulting from personal injuries or death related to the provision of services pursuant to the Participating Provider Agreement.

If the professional liability insurance is written on a 'claims made' basis, practitioner agrees that:

(1) if the Participating Provider Agreement is terminated, the practitioner will continue this insurance with the same or greater policy limits for a period of at least six years following termination; or (2) if this 'claims made' policy is terminated for whatever reason, practitioner will procure and maintain 'tail' coverage professional liability insurance at the same or greater policy limits as the primary policy for a period of not less than six years following the termination of the preceding policy. Practitioner will submit evidence of this insurance to CIGNA in a timely manner. Practitioner will notify CIGNA at least 30 days prior to the expiration, termination, or material change in the coverages listed on the practitioner's application. This provision shall survive the termination of the CIGNA Participating Provider Agreement.

Compensation

1. Practitioners are to accept reimbursement from CIGNA in the amount set forth in and in accordance with the CIGNA Participating Provider Agreement, its Exhibit(s) and the terms of the Medicare Participant's Plan, as full payment for Covered Services. The rates shall apply to all Covered Services. CIGNA shall notify practitioner of the Copayment, Deductible, or Coinsurance, if any, which shall be charged to the Medicare Participant pursuant to the Medicare Participant's coverage under his/her Plan.
2. Practitioners are to submit an itemized bill for Covered Services personally rendered, on forms acceptable to CIGNA within sixty days of the Service date. Practitioner shall supply any additional information reasonably requested by CIGNA to verify that practitioner rendered Covered Services and the usual charges for such services. CIGNA may deny payment for claims not submitted within sixty days from the Service date, unless practitioner can demonstrate to CIGNA's satisfaction that there is good cause for such delay. The practitioner will not be in default if coordination of benefits precludes a timely submission of a bill. The practitioner will submit the bill as soon as reasonably possible after coordination of benefits activities. Payment may be denied for services that are not Covered Services, not Medically Necessary, or if the Medicare Participant was not eligible for coverage under the Plan.

Physician Incentive Plan (PIP)

PIP regulations require disclosure of financial relationships between CIGNA and practitioner who could put practitioner at significant risk. CMS seeks to ensure that they are aware of financial incentives for practitioners to withhold referrals for medical care. There is an elaborate process established to calculate 'significant financial risk'. The process requires consideration of numbers of enrollees involved and whether the financial arrangements involve agreements such as capitation, withholds, or bonuses. Physician practitioners are required to secure CIGNA's prior approval of any practitioner incentive arrangements relating to Medicare agreement participants.



1. Prior to the execution of the CIGNA Participating Provider Agreement and throughout the term of the Agreement, practitioner shall submit to CIGNA and secure CIGNA's prior approval of any practitioner incentive arrangements relating to Medicare Agreement Participants and the Covered Services rendered. CIGNA has the right to disclose such arrangements if required to do so by applicable laws and regulations. Practitioner shall maintain at their sole expense any stop-loss coverage required to be maintained by applicable law in connection with any such practitioner incentive arrangements and shall provide evidence of such coverage upon request.
2. Prior to the execution of the CIGNA Participating Provider Agreement, practitioners shall secure approval from CIGNA with regard to the percentage of the total Covered Services under the Agreement which may be 'referral services' as that term is defined under applicable laws and regulations. Practitioner shall not change the percentage of referral services without CIGNA's prior written approval.

Obligations Under Federal Funding

Payments received in connection with services rendered to Medicare Advantage participants are, in whole or in part, from Federal funds. Recipients of such payments are subject to certain laws that are applicable to individuals and entities receiving Federal funds, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other applicable laws and rules. Also, in order to comply with the Centers for Medicare and Medicaid Services (CMS) requirements for Medicare Advantage organizations, CIGNA and Medicare Advantage organizations must follow federal regulations identified in the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. All written arrangement between a practitioner and downstream entities must comply with applicable Medicare laws and regulations. All practitioners must agree to comply with the Medicare Advantage organization's policies and procedures.

EAP

The Employee Assistance Professionals Association's (EAPA) definition of an EAP is: ". . . a workplace-based program designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns including, but not limited to: alcohol, drug, legal, emotional, stress, and other personal concerns which may adversely affect employee job performance."

Key objectives of EAP programs are to:

- Support employers through assistance for employees to constructively manage personal problems, which may have a negative impact on job performance.
- Work closely with employer's health care benefit programs and local community resources.
- Accurately and quickly match client needs with appropriate resources for assistance.

CIGNA's EAP services are promoted as a resource to assist employers, employees and their household members in identifying and resolving issues of daily life. The program offers participants a work life service with lifecycle information, consultation



and referral as well as the opportunity for short-term counseling with professionals skilled in the assessment and treatment of a wide range of problems. The results for the sponsoring organization can be significant: higher employee productivity, prevention of potentially costly problems in the workplace, the comfort of professional assistance in response to a critical incident and the retention of good employees who appreciate their organizations efforts to maintain a healthier workforce.

A "participant" is:

“. . . the eligible employee and his/her household members."

CIGNA's EAP Models

Assessment and Referral (A&R)

Assessment and Referral entails one to three face-to-face sessions focusing on participant problem identification and resolution or referral to appropriate resources to complete problem resolution.

Short-Term Counseling (STC)

Short-Term Counseling focuses on the resolution of the presenting problem within the EAP. The most common for CIGNA's short-term therapy model are five to eight session programs.

Participation in our EAP/Short-Term Counseling (STC) plans has been increasing. This product includes more than three sessions and sometimes up to twelve. The goal of this product is to try and achieve problem resolution within the EAP STC. If, after assessing, you determine that is not an appropriate goal, you should refer on to the behavioral health benefit. Again, you must contact us when the EAP STC assessment is complete.

Stand-Alone EAP Services

CIGNA is the participant's practitioner for only EAP services. Behavioral health care services are not covered through CIGNA. Stand-alone EAPs may be either A&R or STC.

Integrated EAP Services

CIGNA is the participant's practitioner of both EAP and Behavioral Health Care services. Integrated EAP models may also be either A&R or STC.

If you are participating with CIGNA to see EAP participants, you are well aware of our face-to-face counseling program. The majority of our EAP customers have a one to three EAP model: Assess and Refer. This model gives you up to three sessions to formulate a participant's situation, communicate those findings to the participant, and if ongoing care is necessary, make a referral into the participant's behavioral health benefit. There are two important things to remember:

- Where clinically appropriate, you may refer the participant to yourself for continuing care; and
- You must contact us to close the EAP case once the assessment is complete.

Exclusions

The CIGNA EAP benefit excludes coverage for:

- Psychiatric Evaluations
- Psychological Testing
- Court-Ordered Treatment



- Workers' Compensation/Disability Management
- Medication Management
- Fitness for Duty/Return to Work Determinations

Non-clinical services not covered by the EAP include:

- Employment Law

Special Note: Coverage for Employment Law is excluded due to the dual nature of the EAP client—the individual employee (family participant) and the employer who sponsors the program. Any legal information or advice given by a practitioner to an individual client concerning employment law can have potentially detrimental consequences for the employer client. To avoid this conflict of interest, Employment Law services are excluded from the program. In the course of providing EAP services, practitioners shall refrain from discussing legal recourse as a potential action in resolving workplace concerns or disputes. Employees with concerns about workplace practices should be

referred to their Human Resources department for further assistance.

Examples of excluded employment law questions or concerns are:

- Workplace safety, accidents, injuries, or illnesses;
- Coworker liability (including workplace assaults or threats);
- Employee benefits issues/disputes or disputes concerning the agents of company-sponsored benefits or services;
- Pension rights, employment termination, retirement questions or disputes;
- Employer-based civil rights violations (including workplace sexual harassment allegations); and
- All other alleged employer liability issues.

Eligibility

Unlike behavioral health care services, in all but a very few cases eligibility for EAP services is not verified. Employees, their dependents and their household members are eligible for EAP services. Some customers extend EAP services to retired employees. There is no limit to the frequency with which eligible individuals can access EAP services for new problems or concerns.

Types of Referrals

Participants may contact the EAP as soon as they feel consultative assistance may be helpful. To prevent possible adverse impact on job performance, employees with personal concerns are encouraged to contact the EAP. Participation in the EAP is confidential within the limits of the law. Participants may access the EAP in one of three ways: self-referral, management referral or continuation of employment referral.

Self-Referral

An EAP Self-Referral occurs when the participant contacts the EAP directly and voluntarily seeks assistance for a personal concern. The employer is given no information regarding the individual participant's contact.

Management Referral

An EAP Management Referral involves circumstances where the employee has had job performance issues that have generated the referral by a manager or human resources contact. A Management Referral consists of a voluntary assessment



through the EAP wherein the employee is asked, but not required, to consent to the referral and sign a 'Release of Confidential Information' (ROI) (see [Appendix E](#)) between CIGNA and the referring manager. The ROI form will allow the referring party to be informed of the employee's compliance with EAP attendance and recommendations. Participation in the EAP will not jeopardize the employee's job security, promotional opportunities, etc. Conversely, participation in the EAP will not protect the employee from disciplinary action that may result from substandard job performance, conduct infractions or a violation of company policy. EAP practitioners working with Management Referral Cases are expected to work with an assigned CIGNA EAP Consultant who maintains communication with the referring manager. EAP practitioners are not expected to contact the referring manager and should direct inquiries to the CIGNA EAP Consultant.

Management Referral: Practitioner Procedures

- Meet with the Employee:
 - Complete a comprehensive assessment.
 - Formulate a plan to address the workplace performance issues and any areas that may be contributing to the problem. Keep in mind that you have two 'clients' with an EAP Management referral: the employee and the employer.
 - Inform the employee of your specific recommendations and let the employee know that those recommendations will be reported back to the employer. No clinical or diagnostic information will be given to the employer.
 - If a referral is needed, provide the employee with the contact information for the referral resource. Obtain permission from the employee to communicate with the referral resource. Follow up with the referral resource to verify initial compliance.
- Contact the CIGNA EA Consultant with the initial update:
 - EAP dates of Service.
 - Presenting Problem.
 - Diagnostic Impressions (CD, MH, medications, risk of harm).
 - How are the workplace concerns being addressed?
 - Is the employee compliant with EAP process?
 - Date of next EAP appointment.
 - Recommendations or referral? Please provide a name and contact number for the referral resource.

Do not communicate directly with the employer or complete any paperwork for the employee regarding return to work, disability, fitness for duty, etc.

- Update the EA Consultant regarding the employee's compliance:
 - Dates of subsequent EAP appointments.
 - The employee's progress/compliance with the EAP process.
 - If a referral was made, verification that the employee began attending the recommended treatment.
 - Date that the EAP case was closed and any recommendations for continued treatment.

The EA Consultant obtains a signed release via the referring manager and provides the following information:

- Dates of EAP appointments attended or not attended.
- Date of next EAP appointment.



- Any recommendations for services beyond the EAP. The information given to the employer is limited to the level of care, type of referral resource (inpatient, outpatient, etc.), and the name of the treating practitioner and/or facility.
- The employee's demonstrated compliance with the initial recommendations.

Continuation of Employment Referral

An EAP Continuation of Employment Referral is a referral by a manager or human resources representative that has been offered in lieu of termination. Common precipitants to continuation of employment referrals include, but are not limited to, substance abuse policy violations. In this situation, the employee is required to sign an ROI form (see [Appendix E](#)) that allows communication between CIGNA and the referring party. In some cases, the EAP practitioner may be asked to obtain the ROI.

The ROI form will allow management to be informed of compliance with EAP attendance and recommendations. EAP practitioners who receive Continuation of Employment Referrals are expected to work with a CIGNA EAP Consultant who maintains communication with the referring party. It is extremely important that practitioners respond to the inquiries and requests for updates from the EAP Consultant managing the compliance reporting back to the referring manager or company contact, as these cases involve job jeopardy for the participant. Additionally, the CIGNA EAP Consultant will work collaboratively with the EAP practitioner in regard to cases where their provision of Substance Abuse Professional (SAP) services is requested.

Prepaid Benefit

As CIGNA EAP services are free to eligible participants, there are no out-of-pocket expenses or copayments collected by EAP practitioners. If a treatment referral is needed beyond EAP services, the employee or household member will receive expense reimbursement in accordance with his/her health plan coverage. Employees should review such coverage with the EAP practitioner prior to a referral in order to determine what expenses will be covered by his/her medical plan. EAP practitioner questions about coverage should be directed to CIGNA Care Management staff.

Barrier-Free Access

Eligible participants have access to CIGNA's EAP services twenty-four hours a day, three hundred sixty-five days a year through a toll-free telephone number. Licensed clinical professionals in our Care Center address emergency or crisis situations immediately. During routine calls, EAP participants speak with CIGNA Personal Advocates who will review their EAP benefit, discuss their personal concerns and identify local EAP practitioners for referral purposes.

Only in the event of a management/mandatory referral will a CIGNA staff give the EAP practitioner advanced notification of the EAP participant's name, the employer group, presenting problem, type of EAP benefit and type of referral. Unlike health benefits through CIGNA, EAP benefits continue to require preauthorization. All EAP claims should be billed using CPT code 99404.

Self-referring participants may choose to register for EAP services, select a practitioner and receive an authorization for services online at www.cignabehavioral.com. In this case, both the practitioner and participant will receive a letter confirming the approved service.

CIGNA's appointment access standard for routine EAP cases is two business days. If



the EAP practitioner cannot offer an appointment within this timeframe (when it is requested), the participant should be directed back to the CIGNA referral source.

If a participant schedules an appointment and fails to keep it, the practitioner should contact the participant to discuss his/her intentions. The practitioner is expected to report any participant concerns or complaints regarding satisfaction with EAP services to CIGNA.

Assessment and Evaluation

During the assessment, the EAP practitioner identifies the nature of the problem and a possible plan of action. Family, significant others and friends may be included in this process, as appropriate. The EAP assessment routinely focuses on the individual's level of functioning in the workplace, presence of any contributing stressors as well as the need to develop additional coping skills that might enhance job performance and occupational satisfaction. EAP practitioners use information from the assessment to:

- Help the participant clarify the nature of the presenting problem.
- Identify underlying and/or collateral issues, including non-clinical contributing factors (e.g., legal, financial, or child/eldercare needs).
- Evaluate the level of problem/symptom severity.
- In collaboration with the participant, create an appropriate action plan.

CIGNA encourages the EAP practitioner to work with the EAP participant to resolve his/her presenting problems within the available EAP visits whenever possible. All EAP participants must receive a Statement of Understanding (see [Appendix E](#)) at the beginning of the initial session. Should the participant refuse to sign the Statement of Understanding, please so note on the form and place it in the participant's file.

If the EAP participant reveals legally sensitive information regarding the workplace (e.g., sexual harassment, discrimination issues, etc.) and/or requests the practitioner to contact the workplace, please notify a CIGNA EAP Consultant prior to taking any action. Under no circumstances should the EAP practitioner suggest that employee consult with or retain an attorney for the purpose of assessing the potential for legal action against the employer.

EAP practitioners are encouraged to remain aware that, in EAP work, there is a 'dual client' relationship. The practitioner has both the organization/employer and the participant seeking services as the client. In instances where a concern about conflict of interest arises in this dual client relationship, the practitioner is urged to utilize our EAP Consultants as a resource.

Disposition

In order to ensure participants receive appropriate services and value from their EAP program, CIGNA encourages EAP practitioners to work with the participant to resolve the presenting problems within the context of the EAP. If the participant has only EAP benefits with CIGNA, the EAP practitioner will coordinate referrals for ongoing care directly with the participant either to their behavioral health benefits or appropriate community resources.

If CIGNA manages the EAP participant's behavioral care benefits, referrals must be coordinated with a CIGNA Care Manager. The EAP practitioner may request to continue providing care if/when the following criteria are met:



- CIGNA provides both the EAP and behavioral care benefits for the participant;
- Continuation is clinically the most efficacious course of treatment;
- It is the participant's request; and
- At least two other individual practitioner options are communicated

When CIGNA authorizes continuation of care with the EAP practitioner, the practitioner should obtain the participant's signature on the Waiver of Financial Responsibility form (see [Appendix E](#)) and place the form in the participant's file.

If CIGNA does not manage the participant's mental health and substance abuse benefits, or no benefits are available for the participant, the EAP practitioner is expected to facilitate an appropriate transition to alternate resources. This may include referrals to community-based treatment programs or counseling agencies and/or interface with other HMOs, etc. The EAP practitioner is expected to secure an appropriate Release of Information and contact the treatment practitioner or community resource to alert them to the referral and confirm that the appropriate services can be provided.

Information, resources and referrals are also available through the CIGNA EAP for legal, child and elder care, pet care, HealthyRewards® and other work-life needs. The EAP practitioner should direct the participant to call the CIGNA EAP for these services. In addition, EAP practitioners are expected to maintain knowledge of community-based support groups and resources that may offer additional services (e.g., financial concerns, debt management, personal budgeting) and assist in the transition to these resources.

Follow-Up and Case Closure

Approximately forty-five days after a referral is made, a CIGNA Personal Advocate contacts the participant, with prior permission, to assess whether his/her needs were met through the services that were provided. Given this telephonic contact now includes a formal participant satisfaction survey, *it is no longer necessary for the practitioner to distribute the paper survey (EAP Participant Survey, form #00030) at the close of the EAP episode.*

To ascertain the disposition of a case, EAP practitioners are required to contact the participant ten to fourteen days after the conclusion of the EAP episode of care to ensure that the participant has successfully connected with treatment and/or community resources for ongoing care or to confirm that no further assistance is needed. The information on case disposition must be reported back to a CIGNA staff participant in order to close the EAP episode of care. The information required is:

- Dates of service.
- Date of follow-up with the participant.
- Diagnosis.
- Risk assessment.
- Medication status.
- Current chemical dependency issues.
- Confirmation that the Statement of Understanding was signed.
- Recommendation for additional care/resources.
- Name(s) of practitioner(s) to whom the participant was referred.
- Confirmation that the participant was contacted post-EAP and has either successfully engaged in ongoing treatment or that no additional resources are necessary.



Claim Payment Process

All EAP claims should be submitted on the standard CMS-1500 form that can be found online at www.cignabehavioral.com and billed with a CPT code of 99404. EAP claims submitted without the required CPT code will be denied.

Confidentiality

CIGNA's EAP success and credibility hinge on the confidence that the EAP respects the individual's right to privacy and will protect the information they disclose within the parameters of the law. The EAP will maintain the confidentiality of participants and fully disclose conditions that limit confidentiality. EAP practitioners will not share information regarding involvement in the program without the prior knowledge and written permission of the participant, except as required by law. Every effort is made to maintain strict confidentiality with self-referrals, management referrals, and continuation of employment referrals.

Management Consultation and Education

The CIGNA EAP provides a number of consultative and educational tools to help managers recognize and address multiple workplace issues including potential or existing substance abuse problems. Education, training, and reference guides are available to assist supervisors and human resource managers with problem recognition, intervention, EAP referral, follow-up and reintegration of employees into the workplace.

CIGNA EAP services provide Management Consultation by Certified EAP Professionals, on a per case basis, to support supervisors and human resource managers in developing immediate strategies to deal with performance issues, workplace behavior that may be indicative of potential alcohol and/or other drug problems, violence at work and at home, workplace crises, critical incidents and other sensitive situations. Management Consultation is available twenty-four hours a day, three hundred sixty-five days a year.

EAP practitioners are expected to collaborate with a CIGNA EAP Consultant in servicing challenging Management Referral, Continuation of Employment Referral and Workplace Trauma Incidents.

Promotion

CIGNA believes clear communication about the EAP benefit, at the time it is implemented, as well as frequent reminders about the EAP, enhances the visibility of the program and encourages utilization of available services. EAP communication materials include brochures, wallet cards, videos, and guides for managers, newsletter articles, as well as quarterly awareness brochures and posters on wellness, prevention, and personal growth. CIGNA also has an extensive library of Wellness Seminars that are available to EAP customers and delivered on-site at employer locations by EAP practitioners.

In addition, employee orientation sessions, supervisory training, wellness seminars and health/benefit fairs provide an effective means to enhance the visibility of CIGNA's EAP program. CIGNA also provides timely access to EAP information through *Intranet* and *Extranet* sites. These resources provide additional avenues to make the availability of EAP prevention, early intervention, consultation and work/life services known to the organization and its participants.



Practitioner Roles

As a participating CIGNA EAP practitioner, communication is critical to facilitate the effective resolution of participant issues. Our collaborative vision of program services involves the recognition and balancing of both the needs of the employee and employer. A CIGNA EAP Consultant will facilitate communication, when indicated, with the EAP participant's employer. Employers who request information from the EAP provider should be directed to the CIGNA Employee Assistance Consultant. Direct communication between the EAP practitioner and the participant's employer must be reviewed and approved in advance by CIGNA.

EAP Specialty Services

CIGNA's EAP integrates Practitioner Specialty Skills in the provision of Critical Incident Assistance, Substance Abuse Professional Services, Employee Education & Wellness Seminars and Management Training. CIGNA's Provider Relations department facilitates the recruitment, orientation and privileging of EAP practitioners in these EAP specialty service areas.