One Call Medical Inc.

CIGNA HealthCare Quick Reference Guide for Imaging Facilities

Effective June 1, 2007

CIGNA HealthCare has selected National Imaging Associates, Inc. (NIA), working with One Call Medical (OCM)to provide radiology network management services. NIA will provide utilization management services for outpatient MR, CT, and PET imaging procedures. OCM will manage the provider network in certain markets while NIA will process payments for these advanced imaging procedures.

The following services will not be impacted by this relationship:

- Outpatient radiology services other than MR, CT, and PET imaging studies
- CIGNA will continue to perform prior authorization of coverage for interventional radiology procedures (even those that utilize MR/CT technology)

Prior Authorization Implementation Recommendations

As a provider of diagnostic imaging services that require prior authorization, it is essential that you develop a process to ensure that the appropriate authorization number(s) has been obtained.

It is the responsibility of the rendering facility or physician to ensure that prior authorization was obtained, when necessary. Payment will be denied for procedures performed without a necessary authorization, and the member cannot be balance-billed for such procedures.

Procedures Requiring Prior Authorization Under Many CIGNA HealthCare Plans*

- CT Scan
- MRI/MRA
- PET Scan

*A separate authorization number is required for each procedure ordered.

Emergency room, observation, and inpatient imaging procedures do not require prior authorization.
If an emergency clinical situation exists outside of a hospital emergency room, you should proceed with the examination and call NIA at 1-866-214-1703 the next business day to proceed with the normal review process.

Please refer to the enclosed CIGNA/NIA Billable CPT-4 Codes Claim Resolution Matrix for all of the CPT-4 codes that NIA authorizes on behalf of CIGNA HealthCare.

The following recommendations are offered for your review and consideration in developing an effective procedure for your facility. These recommendations are for informational purposes only and are not policies of CIGNA HealthCare or NIA.

Prior Authorization Recommendations

To ensure that authorization numbers have been obtained, the following recommendations should be considered.

- Communicate to all personnel involved in outpatient scheduling that prior authorization is required for the above procedures under many plans.

- If a physician office calls to schedule a patient for a procedure requiring prior authorization, request the authorization number.
- If the referring physician has not obtained prior authorization when required, inform the physician of this requirement and advise them to obtain an authorization by visiting NIA's Web site at www.RadMD.com, or by calling NIA's toll free number, 1-866-214-1703. You may elect to institute a time period in which they need to obtain the prior authorization number, e.g., one business day.
- If a patient calls to schedule an appointment for a procedure that requires authorization, and does not have the authorization number, they should be directed back to the referring physician who ordered the examination.

Checking Authorizations

You can check on the status of patients' authorizations quickly and easily by going to the NIA Web site, www.RadMD.com. After sign-in, visit the **My Exam Requests** tab to view all outstanding authorizations. Check both sides of the member's identification card carefully to determine whether an authorization is required.

Quick Contacts

- Web Site: www.RadMD.com
- Toll-free Phone Number: 1-866-214-1703
- Call Center Hours: Mon-Fri 8 a.m. to 8 p.m. EST
- One Call Medical (OCM) Provider Relations: 1-800-872-2875

Submitting Claims and Checking Claims Status for CIGNA HealthCare Members

NIA offers several approved clearinghouses for submission of electronic claims:

Emdeon (formerly WebMD)	615-885-3700	www.webmdenvoy.com
PayerPath (A Misys Company)	877-623-5706	www.payerpath.com
MedAvant Healthcare Solutions (formerly ProxyMed)	800-586-6870	www.medavanthealth.com
NaviNet	800-526-7276	www.navinetclaims.com
THIN (Availity)	877-334-8446	www.thinedi.com

If you currently have arrangements with a clearinghouse that is not approved, you can simply arrange for your clearinghouse to contact one of the NIA approved clearinghouses (listed above) to arrange for transmission of claims.

It is important to include:

- NIA's Payer ID: NIA11
- NIA's P.O. Box: 1428
- Your National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN)

In addition, NIA offers several online direct submission options for submitting claims. Visit www.RadMD.com as of 6/1/07 for more information on the following applications:

- Direct Connect with FTP
- Direct Submit for the Web
- Submit individual claims online (for CMS-1500s only)

For questions regarding electronic submission, contact edisupport@MagellanHealth.com.

In the event paper claims submission is necessary for a Cigna HealthCare Member, send an original (red ink) CMS-1500 or UB-04 form directly to:

National Imaging Associates
P.O. Box 1428
Maryland Heights, MO 63043

Please send **Magellan/NIA employee-specific claims** on the appropriate paper claim form (UB-04 or CMS-1500) to P.O. Box 1367. Magellan/NIA employee claims will not be accepted electronically.

Other claims services NIA offers include:

- **Checking claims status**: You can check the status of claims payment for submitted claims by signing in on the NIA Web site and clicking on the **My Claims** tab. NIA meets all state and regulatory timely payment requirements.
- **Electronic funds transfer (EFT)**: Through this process, you can request to have certain claims payments directly deposited to your business bank account. To obtain information on how to set up the EFT payment process, go to NIA's Web site as of 6/1/07 at www.RadMD.com.

Claims Filing Requirements

- Complete all required fields on the CMS-1500 or UB-04 form accurately.
- Collect applicable co-payments or co-insurance from members.
- Submit claims for services delivered in conjunction with the terms of your agreement with OCM.
- Use only standard codes sets as established by the Centers for Medicare and Medicaid Services (CMS) or the state of your licensure for the specific claim form (UB-04 or CMS-1500) you are using.
- Submit claims within 60 days of the provision of covered services.
- Bill only for services rendered within the time span of the authorization.
- Contact NIA for direction if authorized services need to be used after the authorization has expired.
- Do not bill the patient for any difference between your OCM contracted reimbursement rate and your non-discounted rate.

NIA will process your claim promptly upon receipt, and complete all transactions within regulatory and contractual standards. NIA will also inform you of any reasons for administrative denials and action steps required to resolve the administrative denial.

Appeals

OCM and NIA support the right of providers to appeal adverse benefit determination. The provider's responsibility is to:

- Review the non-authorization letter or Explanation of Benefit (EOB)/Explanation of Payment (EOP) notification for:
  - The specific reason(s) for the adverse determination;
  - Appeal rights;
  - Appeal procedures and submission timeframe; and,
  - Any specific documents required for submission in order to complete a review of your appeal.
- Follow the process described in the non-authorization letter or EOB/EOP determination notice to submit an appeal.
- Submit all the appeal information in a timely manner.

NIA's responsibility to you is to:

- Inform you in writing, in a clear and understandable manner, the specific reasons for the adverse determination.
- Identify specific information, documents, records, etc., needed to assist in a favorable appeal determination.
- Thoroughly review all information submitted for an appeal.
- Respond to appeals in a timely manner.
- Inform you of any additional appeal options that may be available when an unfavorable appeal determination is rendered.

Retrospective Reviews

Please note that retrospective review of completed procedures may be conducted on a customer-specific basis and if mandated timelines for submission have been met. Retrospective review requests from OCM contracted providers are evaluated to determine whether there was an urgent or emergent situation that prohibited the provider from obtaining pre-authorization for the service. In all cases, if the service was authorized following the review, the claim is paid. If the service is denied, a non-authorization letter is sent to the rendering provider.

Frequently Asked Questions

In this section NIA addresses commonly asked questions received from providers.

Where can I find NIA's Guidelines for Clinical Use of Diagnostic Imaging Examinations?

NIA's Guidelines for Clinical Use of Diagnostic Imaging Examinations can be found on NIA's Web site at www.RadMD.com.

Is prior authorization necessary if CIGNA HealthCare is not the member's primary insurance?

CIGNA HealthCare's prior authorization requirements apply when CIGNA HealthCare is the primary insurer, but not secondary. Please check the prior authorization requirements for the member's primary insurance.

What does the NIA authorization number look like?

The NIA authorization number consists of 8 or 9 alphanumeric characters (e.g., 1234X567). In some cases, the ordering physician may instead receive an NIA **tracking number** (not the same as an authorization number) if the physician's authorization request is not approved at the time of initial contact. Physicians can use either number to track the status of their request on the RadMD Web site or via our Interactive Voice Response telephone system.

How do I submit claims with mixed services?

You should submit claims according to the following guidelines.

- CIGNA HealthCare will continue to process payments for:
  - Inpatient high-tech radiology services
  - Emergency Room radiology services
  - Outpatient radiology services other than MR, CT, and PET imaging studies
- CIGNA HealthCare will also continue to perform prior authorization of coverage for interventional radiology procedures (even those that utilize MR/CT technology).
- NIA will process payments for all outpatient MR, CT, and PET imaging procedures.

✓ **Tips for Free-standing Facilities**
Claims for outpatient, non-emergency MR, CT and PET imaging services should be submitted to NIA; and claims for all other radiology services including inpatient or emergency MR, CT, and PET should be submitted to CIGNA HealthCare.

Who can I contact at OCM or NIA for questions, complaints, and appeals, etc.?

Please use the following contacts by type of issue:

Type of Issue	Resource
Provider Contracting	Contact your OCM Provider Contracting Specialist at 800-872-2875.
Provider Credentialing Appeals	Contact your OCM Credentialing Database Specialist at 800-872-2875.
Prior Authorization and Claims Payment Complaints/Appeals	Follow the instructions on your Non-Authorization Letter or Explanation of Benefits (EOB)/Explanation of Payment (EOP) notification.
Other Questions, Complaints or Appeals not related to Authorizations or Claims	Contact your OCM Provider Relations Specialist at 800-872-2875.

How are claims paid and to what standards is NIA held for timely payment?

NIA has an experienced claims processing division dedicated to timely provider reimbursement. (Our key procedures have been outlined in this Quick Reference Guide and our capabilities are also described in the OCM Provider Manual.) As described previously, you can submit claims via clearinghouses or directly to us via RadMD online, or via mail. NIA and/or CIGNA HealthCare process reimbursements in accordance with the timeframes required by law.

How will referring/ordering physicians know who NIA is?

CIGNA HealthCare will be sending orientation materials to referring providers. CIGNA HealthCare and NIA also have plans to coordinate additional outreach and orientation activities.

How will NIA direct members to my facility?

NIA actively promotes utilization of quality, cost-effective imaging providers by providing patients and referring physicians critical information online and at the point of ordering. Members can obtain an estimate of average out-of-pocket costs for advanced imaging procedures at www.myCIGNA.com and will soon be able to access information on a number of quality (e.g., accreditations, certifications) and convenience indicators (e.g., hours of operation, handicap access, parking). In addition, NIA will alert the referring physicians if a selected imaging provider charges significantly higher rates than others in the surrounding community. Our goal is to assist patients and referring physicians in selecting quality, convenient and cost-effective care for each individual.

Will out-of-area CIGNA HealthCare members be able to use the NIA network when traveling out of state?

Yes, depending on their benefit plan.

Will there be differential in patient responsibility if we do not participate (e.g., co-pays are higher), and how is that determined?

Member co-payment requirements will depend on their benefit plan type regarding in-network versus out-of-network benefits.

What will the member ID card look like? Will it have both NIA and CIGNA HealthCare information on the card? Or will there be two cards?

The CIGNA HealthCare member ID card will not have NIA identifying information on it. CIGNA HealthCare will redirect calls to NIA for advanced imaging in the states NIA is serving on behalf of CIGNA HealthCare.

CIGNA HealthCare/NIA Billable CPT Codes Claim Resolution Matrix

The matrix below contains all of the CPT-4 codes for which National Imaging Associates (NIA) authorizes and renders payment on behalf of CIGNA HealthCare. This matrix is designed to communicate those services that require medical necessity review and assist in the resolution of claims adjudication and claims questions related to those services. If an exam is billed under any one of the given codes for that grouping and a valid authorization number has been issued within the date of service validity period, NIA will consider the claim to be authorized.

If a family of CPT codes is not listed in this matrix, an exact match is required between the authorized CPT code and the billed CPT code. If the exact match does not occur, NIA will consider the claim to be unauthorized.

*Please note: Services rendered in an Emergency Room, observation room, surgery center or hospital inpatient setting are not subject to the NIA pre-authorization program.

Authorized CPT Code	Description	Allowable Billed Groupings
70336	MRI Temporomandibular Joint[1]	70336
70450	CT Head/Brain[1]	70450, 70460, 70470
70480	CT Orbit[1]	70480, 70481, 70482
70486	CT Maxillofacial/Sinus[1]	70486, 70487, 70488, 76380
70490	CT Soft Tissue Neck[1]	70490, 70491, 70492
70496	CT Angiography, Head[1]	70496
70498	CT Angiography, Neck	70498
70540	MRI Orbit, Face, and/or Neck[1]	70540, 70542, 70543
70551	MRI Internal Auditory Canal[1]	70551, 70552, 70553, 70540, 70542, 70543
70544	MRA Head[1]	70544, 70545, 70546
70547	MRA Neck[1]	70547, 70548, 70549
70551	MRI Brain[1]	70551, 70552, 70553
70554	Functional MRI Brain; including test selection and administrative of repetitive body part movement and/or visual stimulation; requiring physician or psychologist administration[1]	70554, 70555
71250	CT Chest[1]	71250, 71260, 71270
71275	CT Angiography, Chest (non coronary) [1]	71275
71550	MRI Chest[1]	71550, 71551, 71552
71555	MRA Chest (excluding myocardium) [1]	71555
72125	CT Cervical Spine[1]	72125, 72126, 72127
72128	CT Thoracic Spine[1]	72128, 72129, 72130
72131	CT Lumbar Spine[1]	72131, 72132, 72133
72141	MRI Cervical Spine[1]	72141, 72142, 72156
72146	MRI Thoracic Spine[1]	72146, 72147, 72157
72148	MRI Lumbar Spine[1]	72148, 72149, 72158
72159	MRA Spinal Canal[1]	72159
72191	CT Angiography, Pelvis[1]	72191
72192	CT Pelvis[1]	72192, 72193, 72194

[1] NIA/Magellan guidelines utilized for clinical determinations. Please go to: http://www.radmd.com/misc_pages/clinical_guidelines.htm

National Imaging Associates, Inc.

Authorized CPT Code	Description	Allowable Billed Groupings
72196	MRI Pelvis[1]	72195, 72196, 72197
72198	MRA Pelvis[1]	72198
73200	CT Upper Extremity[1]	73200, 73201, 73202
73206	CT Angiography, Upper Extremity[1]	73206
73220	MRI Upper Extremity, other than Joint[1]	73218, 73219, 73220
73221	MRI Upper Extremity Joint[1]	73221, 73222, 73223
73225	MRA Upper Extremity[1]	73225
73700	CT Lower Extremity[1]	73700, 73701, 73702
73706	CT Angiography, Lower Extremity[1]	73706
73720	MRI Lower Extremity, other than Joint[1]	73718, 73719, 73720, 73721, 73722, 73723
73721	MRI Lower Extremity Joint[1]	73721, 73722, 73723, 73718, 73719, 73720
73721	MRI Hip[1]	72195, 72196, 72197, 73721, 73722, 73723
73725	MRA Lower Extremity[1]	73725
74150	CT Abdomen[1]	74150, 74160, 74170
74175	CT Angiography, Abdomen[1]	74175
74181	MRI Abdomen[1]	74181, 74182, 74183, S8037
74185	MRA Abdomen[1]	74185
75552	MRI Heart[1]	75552, 75553, 75554, 75555, 75556
75635	CT Angiography, Abdominal Arteries[1]	75635
76380	CT Limited or Follow-Up[1]	76380
76390	MR Spectroscopy (CIGNA CP#0244)[2]	76390
77058	MRI Breast[3]	77058, 77059
77078	CT Bone Mineral Density Study, Axial[1]	77078
77079	CT Bone Mineral Density Study, peripheral[1]	77079
77084	MRI Bone Marrow[1]	77084
78459	PET Scan, Heart (CIGNA CP#0091)[2]	78459, 78491,78492
78608	PET Scan, Brain (CIGNA CP#0091)[2]	78608, 78609
78813	PET Scan, Tumor Imaging (CIGNA CP#0091)[2]	78811, 78812, 78813, 78814, 78815, 78816
78816	Tumor Imaging, PET with concurrently acquired CT for attenuation correction and anatomic, localization. (CIGNA CP#0091)[2]	78811, 78812, 78813, 78814, 78815, 78816
G0235	PET imaging, any site, not otherwise specified (CIGNA CP#0091)[2]	G0235
0145T	CT Heart (CIGNA CP#0399)[2]	0145T, +0151T
0148T	CT Heart, including cardiac structure, and morphology and computed tomographic angiography of coronary arteries including native and anomalous coronary arteries, and coronary bypass grafts[2]	0148T, 0146T, 0147T, 0149T
0150T	CT Heart congenital studies, non-coronary arteries CIGNA CP#0399)[2]	0150T, +0151T
0144T	Computed Tomography, without contrast, quantitative evaluation of coronary calcium[2]	0144T
S8037	MR Cholangiopancreatography[1]	S8037, 74181, 74182, 74183
0066T	Screening CT Colonoscopy (Virtual Colonoscopy, CT Colonography) (Cigna CP#0083)[2]	0066T
0067T	Diagnostic CT Colonoscopy (Virtual Colonoscopy, CT Colonography) (Cigna CP#0093)[2]	0067T

Note: Cerebral profusion analysis CT (0042T) is considered by CIGNA HealthCare to be Investigational and will not be reimbursed.

[2] CIGNA HealthCare medical policy exists; to review, please go to:
http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/index.html
[3] CIGNA HealthCare policy states that when a Breast MRI is performed, there is no additional reimbursement when CAD (Computer Aided Detection) for lesion detection is performed.

2

One Call Medical Fee Schedule Mapping

Computerized Tomography Procedures

CPT-4 or HCPCS Code	DESCRIPTION	OCM CATEGORY
70450, 70480, 70486, 70490, 71250, 72125, 72128, 72131, 72192, 73200, 73700, 74150	CT Scan without contrast – head; orbit, sella, or posterior fossa, or ear; maxillofacial; soft tissue neck; thorax; cervical spine; thoracic spine; lumbar spine; pelvis; upper extremity; lower extremity; abdomen	CT without contrast
70460, 70481, 70487, 70491, 71260, 72126, 72129, 72132, 72193, 73201, 73701, 74160	CT Scan with contrast – head; orbit, sella, or posterior fossa, or ear; maxillofacial; soft tissue neck; thorax; cervical spine; thoracic spine; lumbar spine; pelvis; upper extremity; lower extremity; abdomen	CT with contrast
70470, 70482, 70488, 70492, 70496, 70498, 71270, 71275, 72127, 72130, 72133, 72191, 72194, 73202, 73206, 73702, 73706, 74170, 74175, 75635, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T	CT Scan without contrast and followed by contrast – head; orbit, sella, or posterior fossa, or ear; maxillofacial; soft tissue neck; CTA head; CTA neck; thorax; CTA chest; cervical spine; thoracic spine; lumbar spine; CTA pelvis; pelvis; upper extremity; CTA upper extremity; lower extremity; CTA lower extremity; abdomen; CTA abdomen; CTA abdominal arteries; CT heart cardiac structure & morphology; CTA heart w/o CA eval, CTA w/ CA eval, CTA heart cardiac structure & morphology w/o CA eval, CTA heart cardiac structure & morphology w/ CA eval, CT heart structure & morphology in congenital heart disease	CT with and without contrast

Magnetic Resonance Procedures

CPT-4 or HCPCS Code	DESCRIPTION	OCM CATEGORY
70336, 70540, 70544, 70547, 70551, 71550, 72141, 72146, 72148, 72195, 73218, 73221, 73718, 73721; 74181, 75552	MR without contrast – temporomandibular joints; orbit, face, & neck; MRA head; MRA neck; brain; chest; cervical spine; thoracic spine; lumbar spine; pelvis; upper extremity other than joint; joint of upper extremity; lower extremity other than joint; joint of lower extremity; abdomen; cardiac for morphology	MR without contrast
70542, 70545, 70548, 70552, 71551, 71555, 72142, 72147, 72149, 72159, 72196, 72198, 73219, 73222, 73225, 73719, 73722, 73725, 74182, 74185, 75553	MR with contrast – orbit, face, & neck; MRA head; MRA neck; brain; chest; MRA chest; cervical spine; thoracic spine; lumbar spine; MRA spinal canal & contents; pelvis; MRA pelvis; upper extremity other than joint; joint of upper extremity; MRA upper extremity; lower extremity other than joint; joint of lower extremity; MRA lower extremity; abdomen; MRA abdomen; cardiac for morphology	MR with contrast
70543, 70546, 70549, 70553, 71552, 72156, 72157, 72158, 72197, 73220, 73223, 73720, 73723, 74183, 77058*, 77059*	MRI without contrast and followed by contrast – orbit, face, & neck; MRA head; MRA neck; brain; chest; cervical spine; thoracic spine; lumbar spine; pelvis; upper extremity other than joint; joint of upper extremity; lower extremity other than joint; joint of lower extremity; abdomen; breast unilateral; breast bilateral	MR with and without contrast

Positron Emission Tomography Procedures[1]

CPT-4 or HCPCS Code	DESCRIPTION	CATEGORY
78459, 78491, 78492, 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816	Myocardial imaging – metabolic evaluation, perfusion single study at rest or stress, multiple studies at rest or stress; Brain imaging – metabolic evaluation, perfusion evaluation; Tumor imaging – limited area, skull base to mid-thigh, whole body; Tumor imaging PET-CT with attenuation correction & anatomical localization – limited area, skull base to mid-thigh, whole body	PET Procedures

Other CT and MR Procedures

77078, 77079, 76380, 75554, 75555, 75556, 77084	CT bone mineral density study - axial, peripheral; CT limited or localized follow-up study any area; Cardiac MRI – for function with or without morphology as complete study, for function with or without morphology as limited study, for velocity flow mapping; MRI – bone marrow blood supply
76376, 76377, 0151T	CT multiplanar reconstructions, CT heart function evaluation

Notes:

* Includes computer-aided detection and further physician review (0159T).

1. PET, PET with fusion, and PET-CT fusion studies will be reimbursed as a single PET procedure and are inclusive of Radiopharmaceutical Diagnostic Imaging Agent doses.
2. Reimbursement for services for all facilities may be adjusted by OCM or its payers using the discounting methodologies described by the CMS Multiple Procedure Discount (MPD) policies as published by CMS as of September 1, 2006. Any future changes to the MPD methodologies will be communicated via amendment to the OCM agreement as required by the terms defined therein.
3. This document represents the most frequently utilized CPT and HCPCS codes for advanced imaging services. Rates for CPT and HCPCS codes not listed can be obtained from One Call Medical (OCM) upon request and will be provided at the time services are authorized.
4. OCM or its claims payers will not accept expired or deleted CPT and HCPCS codes. Please use and submit current CPT and HCPCS codes for all services.