# ACU-CARE Payor Summary & Election to Participate with CIGNA HEALTHCARE OF CALIFORNIA, HMO

**Payor Name:** CIGNA HealthCare of California ("Cigna")
**Product:** Group Health, HMO
**Effective Date:** January 1, 2005

## CONTRACT RATE SUMMARY

**Reimbursement rates:** The following rates cover all Provider charges for Ancillary Services provided to Members. These rates are inclusive of all medically necessary services that Provider customarily provides to patients requiring the particular service. Any procedures or services not intended by Provider to be included in the rates must be fully defined and a description attached hereto.

| Procedure Codes | Code | Contract Rate |
|---|---|---|
| Acupuncture, First 15 minutes | 97810 | $57.00 |
| Acupuncture, Additional 15 minutes | 97811 | $38.00 |
| Electro Stimulation, First 15 minutes | 97813 | $66.00 |
| Electro Stimulation, Additional 15 minutes | 97814 | $44.00 |

All other Covered Services shall be reimbursed at 100% of Resource Based Relative Value Scale (RBRVS) in effect by CGLIC for that calendar year based upon the Los Angeles Geographical Practice Cost Index. Unlisted or uncoded procedures will be paid at fifty percent (50%) of billed charges or up to the seventieth percentile (70%) of reasonable and customary rates whichever is less.

**Copayments/Coinsurance/Deductibles**
Provider will collect any applicable copayment or Deductible from the Member at the time service is rendered. Provider will collect any Coinsurance from the member after provider has billed and received payment from CGLIC.

**Reciprocity:** The rates set forth above shall apply to all Managed Care Plans of CIGNA or CIGNA Affiliates.

**Prior Authorization:**
Services other than Emergency Services—Provider shall verify eligibility prior to providing the service and shall secure prior authorization for each Member from CIGNA. When a determination is made that Emergency Services are required, Provider shall not be required to obtain prior authorization from CIGNA, provided that Provider shall notify CIGNA as soon as possible, but in no event more than twenty-four (24) hours after the Emergency Services are provided. Failure by Provider to obtain prior authorization from CIGNA for Ancillary Services other than Emergency Services shall result in denial of payment for the unauthorized Services rendered to Members.

**Claims submissions:** Provider shall submit claims for Ancillary Services to the address provided on the back of the Member's I.D. Card, within ninety (90) days of the date those services are rendered. Cigna will not pay claims received after this 90-day period.

**Maximum Rates**
Reimbursement rates established here, represent maximum reimbursement amounts from CIGNA to Provider. Actual reimbursement to Provider shall be the lesser of usual and customary charges or the contracted reimbursement rates.

**CIGNA Medical Coverage Policy:**
Acupuncture is specifically excluded under many benefit plans. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage. Some plans that provide coverage for acupuncture include a maximum allowable benefit for duration of treatment or number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described below are met.

If coverage is available for acupuncture, the following conditions of coverage apply.

CIGNA covers acupuncture as medically necessary for any of the following indications:

- nausea and vomiting associated with pregnancy

- nausea and vomiting associated with chemotherapy
- postoperative nausea and vomiting
- postoperative dental pain
- the treatment of pain associated with ANY of the following chronic conditions:
  - migraine or tension headache
  - osteoarthritic knee pain
  - neck pain
  - low back pain

CIGNA does not cover acupuncture for any other indication, because it is considered experimental, investigational or unproven.

CIGNA does not cover acupuncture point injection for ANY indication because it is considered experimental, investigational or unproven.

I hereby agree to provide health care services and benefits to Beneficiaries of the above named Payor in accordance with the terms and conditions of the Agreement and this Payor Summary.

____________________________________________________
Name (print)

____________________________________________________ ______________________
Signature Date