



CIGNA REIMBURSEMENT POLICY

The following Reimbursement Policy applies to all plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

Subject Never Events and Avoidable Hospital Conditions

Original Effective Date.....10/01/2008
[Policy History/Updates](#)
Reimbursement Policy Number R05

Table of Contents

Reimbursement Policy	1
General Background	1
Coding Requirements.....	5
References	8
Policy History/Updates	10

INSTRUCTIONS FOR USE

Reimbursement policies are intended to supplement certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these reimbursement policies are based. For example, an individual's benefit plan document may contain a specific exclusion related to a topic addressed in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supercedes** the information in a reimbursement policy. Proprietary information of CIGNA. Copyright ©2009 CIGNA

Reimbursement Policy

CIGNA does not provide reimbursement for “never events” as they are not medically necessary.

CIGNA does not provide reimbursement for avoidable hospital conditions as defined in this policy when permitted by contract.

This policy, along with provider contracting initiatives and provider transparency strategies, is intended to improve hospital reporting, help reduce the number of these events, assist the member in becoming more informed regarding hospital quality issues and to more closely align our practices with CMS (Centers for Medicare and Medicaid Services).

General Background

The Leapfrog Group, founded in 2000, is an employer-led group of more than 145 organizations “that sponsor health care benefits and support the use of their purchasing power to initiate breakthrough improvements in the safety, quality and affordability of health care”. Based on the National Quality Forum (NQF) “never events” definition, the Leapfrog Group encourages hospitals to adhere to the following initiatives:

- Apologize to the patient and/or family affected by the never event;
- Report the event to at least one of the following agencies: the Joint Commission, a state reporting program for medical errors; a Patient Safety Organization.
- Perform a root cause analysis consistent with instructions from the chosen reporting agency, and
- Waive all costs directly related to the serious reportable adverse event.

The National Quality Forum, a private organization whose members include the American Medical Association (AMA), defines “never events” as “errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility”.

In order to be included in the NQF list of “never events”, the following criteria must be met:

- “Unambiguous – clearly identifiable and measurable, and thus feasible to include in a reporting system;
- Usually preventable – recognizing that some events are not always avoidable, given the complexity of health care;
- Serious – resulting in the death or loss of a body part, disability, or more than transient loss of a body function, and
- Any of the following:
 - Adverse and/or
 - Indicative of a problem in the health care facility’s safety systems and/or, important for public credibility or public accountability.”

Never Events

Procedures performed on the wrong side, wrong body part, wrong procedure or wrong person are referred to in this policy as “Never Events”. These Never Events are not medically necessary¹ as they are not required to diagnose or treat an illness, injury, disease or its symptoms and are not consistent with generally accepted standards of medical practice. All Never Events involving a wrong procedure, or a procedure performed on the wrong side, wrong body part, or wrong person are considered not medically necessary, and no reimbursement is allowed for Never Events. Hospitals generally refrain from billing members for these Never Events. In addition, billing patients for these Never Events is not consistent with CMS guidelines, or the National Quality Forum Leapfrog Quality Initiatives.

Wrong-side, wrong-site, wrong-procedure, and wrong person adverse events (WSPEs) are devastating, unacceptable, and often result in litigation. WSPEs are likely more common than is generally realized. Beginning in July 2004, Joint Commission-accredited hospitals were required to adhere to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery by implementing time outs and site verifications for all invasive procedures (Norton E., 2007). Higher-level policies or programs have been implemented by the American Academy of Orthopaedic Surgery, Joint Commission on Accreditation of Healthcare Organizations, Veteran’s Health Administration, Canadian Orthopaedic, and the North American Spine Society Associations to reduce wrong site surgery. (Michaels RK, et. al., 2006)

Seiden and Barah (2006) published an analysis of several databases that demonstrated that Never Events occur across all specialties, with high numbers noted in orthopedic and dental surgery. Databases analyzed included: (1) the National Practitioner Data Bank (NPDB), (2) the Florida Code 15 mandatory reporting system, (3) the American Society of Anesthesiologists (ASA) Closed Claims Project database, and (4) a novel Web-based system for collecting WSPE cases (<http://www.wrong-side.org>). Results showed that the NPDB recorded 5940 Never Events (2217 wrong-side surgical procedures and 3723 wrong-treatment/wrong-procedure errors) in 13 years. Florida Code 15 occurrences of WSPEs number 494 since 1991, averaging 75 events per year since 2000. The ASA Closed Claims Project has recorded 54 cases of WSPEs. Analysis of WSPE cases, including WSPE cases submitted to <http://www.wrong-side.org>, suggest several common causes of WSPEs and recurrent

¹ A typical definition of medical necessity is as follows:

Medically Necessary Covered Services and Supplies are those determined by the Healthplan Medical Director to be:

- Required to diagnose or treat an illness, injury, disease or its symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in terms of type, frequency, extent, site and duration; and
- Not primarily for the convenience of the patient, Physician, or other health care provider; and
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Healthplan Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining the least intensive setting.

systemic failures. Based on these findings, they estimated that there are 1300 to 2700 WSPEs annually in the United States. Despite a significant number of cases, they noted that reporting of WSPEs is virtually nonexistent, with reports in the lay press far more common than reports in the medical literature. Research suggests clear factors that contribute to the occurrence of WSPEs, as well as ways to reduce them. They concluded that wrong-side/wrong-site, wrong-procedure, and wrong-patient adverse events, although rare, are more common than health care providers and patients appreciate. Prevention of WSPEs requires new and innovative technologies, reporting of case occurrence, and learning from successful safety initiatives (such as in transfusion medicine and other high-risk nonmedical industries), while reducing the shame associated with these events.

Kwaan MR et. al. (2006) published a case series and survey of wrong-site/procedure/person procedures. Data was obtained from hospitals and a malpractice liability insurer. All wrong-site surgery cases reported to a large malpractice insurer between 1985 and 2004 were reviewed. Incidence, characteristics, and causes of wrong-site surgery and characteristics of site-verification protocols were reviewed. Results showed that among 2,826,367 operations at insured institutions during the study period, 25 nonspine wrong-site operations were identified, producing an incidence of 1 in 112,994 operations (95% confidence interval, 1 in 76,336 to 1 in 174,825). Medical records were available for review in 13 cases. Among reviewed claims, patient injury was permanent-significant in 1, temporary-major in 2, and temporary-minor or temporary-insignificant in 10. Under optimal conditions, the Joint Commission on Accreditation of Healthcare Organizations Universal Protocol might have prevented 8 (62%) of the 13 cases. Hospital protocol design varied significantly. The protocols mandated 2 to 4 personnel to perform 12 separate operative-site checks on average (range, 5-20). Five protocols required site marking in cases that involved nonmidline organs or structures; 6 required it in all cases. The authors concluded that wrong-site surgery is unacceptable but exceedingly rare, and major injury from wrong-site surgery is even rarer. Current site-verification protocols could have prevented only two thirds of the examined cases.

CMS has adopted a national payment policy that all Wrong Site/Procedure/Person procedures (E876.5) are never reimbursed to facilities.

CIGNA has concluded that procedures for the wrong site, wrong procedure or wrong person are not medically necessary as they are not required to diagnose or treat an illness, injury, disease or its symptoms and/or are not within generally accepted standards of medical practice. All such Never Events will be denied for lack of medical necessity.

Case Example #1: A patient is taken to the operating room for an operative procedure on the left knee. Through an error, the physician operates on the normal right knee and discovers the mistake only when he determines during the surgery that the anatomy of the knee is perfectly normal. The physician terminates the procedure and orders the patient to the recovery room. After the patient has recovered from the anesthesia, the physician explains to the patient and the family that because of an error, the wrong knee was operated on. The physician apologizes for the error and agrees not to bill the patient for the procedure. Later that day, a hospital official also discusses the error and apologizes to the family and agrees that the hospital will not bill the patient or his insurance carrier for the procedure. In this case, the operative procedure on the right knee was not medically necessary as it was not required to diagnose or treat an illness, injury, disease or its symptoms and/or was not within generally accepted standards of practice.

Avoidable Hospital Conditions

Avoidable Hospital Conditions (a.k.a. hospital acquired conditions) are conditions “which could reasonably have been prevented through application of evidence-based guidelines.” These conditions are not present when patients are admitted to a hospital, but present during the course of the stay.

Using the criteria developed by the National Quality Forum (NQF), and working with other groups, including providers to identify quality standards that can be a basis for public reporting and payment, the Centers for Medicare and Medicaid Services (CMS) launched a number of initiatives to improve the quality of health care. These initiatives were taken as a result of the Deficit Reduction Act (DRA) of 2005, Section 5001 C. Under the DRA, CMS was required to select conditions that were consistent with the following:

- High cost, high volume, or both;
- Assigned to a higher paying DRG when present as a secondary diagnosis;

- Reasonably prevented through the application of evidence-based guidelines

On August 1, 2007, CMS issued a final rule to end payment for the extra care resulting from certain medical mistakes (e.g. hospital acquired conditions (HAC)) effective October 1, 2008. The CMS rule also prohibits passing these charges on to patients. The conditions will be handled at the lower paying DRG when the condition is not present on admission and is the only major complication/co-morbidity (MCC)/complication/co-morbidity (CC) reported. If other secondary diagnoses that are MCC/CC are reported, Medicare will process the admission at the appropriate higher level DRG.

The HAC conditions in the initial CMS ruling and effective October 1, 2008, were as follows:

- foreign objects retained after surgery,
- air embolism,
- blood incompatibility,
- pressure ulcers stages III & IV,
- falls and trauma,
- catheter associated urinary tract infection,
- vascular catheter-associated infection and surgical site infection, and
- mediastinitis, following coronary artery bypass graft (CABG)

In the August 19, 2008 final rule posted in the Federal Register, CMS added additional conditions subject to payment at the lower DRG level if not present on admission effective October 1, 2008. These conditions included the following:

- manifestations of poor glycemic control,
- surgical site infection following certain orthopedic procedures,
- surgical site infection following bariatric surgery for obesity, and
- deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

Case Example #2: A 60 year old female is admitted for a spinal fusion of the lumbar spine. Post surgery, the patient is found to be anemic and requires a blood transfusion. The patient is given the wrong blood type. (ICD-9-CM 999.6). This patient has no other major complications or comorbidities. Due to the reaction to the incompatible blood (hospital acquired condition), the patient's length of stay is prolonged an additional two hospital days. In this case, the additional two inpatient days required as a direct result of the hospital acquired condition (not present on admission) could potentially be denied as a delay in discharge if the provider contract supports such a payment denial, or according to policies, procedures and directives applicable to contracted providers.

Present on Admission

CMS provided that effective October 1, 2007; hospitals should begin submitting inpatient hospital charges with a Present on Admission (POA) indicator. Present on admission is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including the Emergency Department, observation or outpatient surgery, are considered as present on admission.

The provision does not apply to Critical Access Hospitals, Rehabilitation Hospitals, Psychiatric Hospitals, or any other facility not paid under Medicare Hospital IPPS including Maryland Hospitals.

The POA indicator is applicable to both the primary and secondary diagnosis as well as the external cause of injury codes. Categories and codes exempt from reporting are late effect codes, normal delivery, V-codes, and certain external codes (e.g. railway, motor vehicle, water transport, air and space transport).

The POA indicator is submitted in field 67 of the UB-04 and in segment K3 in the 2300 loop, data element K301 for the 837I electronic claim submission. The values for these fields are as follows:

- **Y**=Present at the time of inpatient admission
- **N**=Not present at the time of inpatient admission
- **U**=Documentation is insufficient to determine if condition is present on admission
- **W**=Provider is unable to clinically determine whether condition was present on admission or not

- 1=Exempt from POA reporting. Unreported/Not used. This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A.

To assist with the assignment of the POA indicator, see Appendix I Present on Admission Reporting Guidelines which is a supplement to the ICD-9-CM Official Guidelines for Coding and Reporting at <http://www.cdc.gov/nchs/datawh/ftp/ftp9/ftpicd9/icdguide07.pdf>.

Concurrent Review:

We review admissions with identifiable Never Events and Avoidable Hospital Conditions. If it is determined there were additional hospital inpatient days at a participating provider facility which directly and exclusively resulted from an Avoidable Hospital Condition (not present on admission), reimbursement for such additional inpatient days may be denied when permitted by the terms of the facility's provider contract, or according to policies, procedures and directives applicable to contracted providers. Denials for inpatient hospital days which are the result of a delay in discharge due to inadequate nursing staff or procedure, or in violation of policies, procedures and directives applicable to contracted providers, are not billable to the member under the terms of most CIGNA hospital contracts. These reimbursement denials will not apply to hospital admissions in which the Avoidable Hospital Condition was present on admission, or where another secondary diagnosis is a major complication/co-morbidity (MCC)/complication/co-morbidity (CC) in addition to the POA diagnosis, and potentially impacted the Avoidable Hospital Condition.

Provider Transparency:

CIGNA believes our members should have access to information concerning hospital quality and safety. Information concerning mortality rates, hospital complications, patient safety, and participation in National Quality Forum's Leapfrog Initiatives are included in CIGNA's hospital quality tool available on CIGNA's website for our members. For more information, see CIGNA's website at: <http://cigna.benefitnation.net/cignams/searchhosp.asp>.

Hospitals are encouraged to adopt the Leapfrog Group's policies on patient safety to help reduce hospital errors and improve the quality and affordability of health care. To review the Leapfrog Hospital Quality and Safety Survey, or to determine if a hospital has implemented one or more patient safety standards outlined by the Leapfrog Group, click on the following link: <http://www.leapfroggroup.org/cp>.

SUMMARY

CIGNA's policy on Never Events and Avoidable Hospital Conditions is designed to encourage hospitals to improve patient safety and reduce avoidable error rates. Operations on the wrong site, wrong operation, or wrong person are Never Events and are not medically necessary.

Avoidable Hospital Conditions which were not present on admission are reasonably preventable through the application of appropriate evidence-based protocols. Avoidable Hospital Conditions may result in more serious outcomes to the patient, including death, loss of function, and disability. Avoidable Hospital Conditions may also lead to longer lengths of stay or delays in discharge.

Consumers should have access to information concerning hospitals comparative rates of complications, quality and patient safety measures, as well as whether the facility participates in Leapfrog Initiatives.

Coding Requirements

Coding for Conditions Present on Admission:

In order to identify and monitor Never Events and Avoidable Hospital Conditions, the inclusion of the appropriate ICD-9 CM code and Present on Admission (POA) indicator are required on claims submitted to CIGNA, effective

October 1, 2008. All hospitals should code claims submitted to CIGNA with Present on Admission indicators. This information should be included in field -67 of the UB-04 paper claim and in segment K3 in the 2300 loop, data element K301 for the 837I electronic claim submission. After October 1, 2008, CIGNA reserves the right to return any claim without a POA indicator. In addition, as part of CIGNA's Quality Management Program, CIGNA may request additional medical records for admissions involving Never Events and Avoidable Hospital Conditions, not present on admission.

In administering this policy, CIGNA will seek to use published CMS Medicare guidelines, whenever such are consistent with our benefit plans and hospital contracts.

Never Events

"Never Event"	ICD-9 CM Code	ICD-9 CM Code Description
Wrong surgery; wrong patient	E876.5	Performance of inappropriate operation

Hospital Acquired Conditions (a.k.a. Avoidable Hospital Conditions)

Serious Preventable Event	ICD-9 CM Code	ICD-9 CM Code Description
Objects left in surgery	998.4	Foreign body, accidentally left during procedure, not elsewhere classified.
	998.7	Acute reaction to foreign substance accidentally left during a procedure.
Air embolism	999.1	Air embolism as complication of medical care, not elsewhere classified.
Blood incompatibility	999.6	ABO, incompatibility reaction, not elsewhere classified.
Catheter Associated Urinary Tract Infection	996.64 Also excludes the following from acting as a CC/MCC: 112.2 590.10 590.11 590.2 590.3 590.80 590.81 595.0 597.0 599.0	Infection and inflammatory reaction due to indwelling urinary catheter; Use additional codes to identify specified infections as indicated in coding column. Candidiasis of other urogenital sites Acute pyelonephritis without lesion of renal medullary necrosis Acute pyelonephritis with lesion of renal medullary necrosis Renal and perinephric abscess Pyeloureteritis cystica Unspecified pyelonephritis Pyelitis or pyelonephritis in diseases classified elsewhere Acute cystitis Urethral abscess Urinary tract infection, site not specified
Pressure Ulcers (Decubitus Ulcers)	New codes (effective 10/1/08) 707.23 and 707.24 will replace 707.00 – 707.09. All other pressure ulcer codes will not be a CC.	Decubitus ulcer, Stage III and Stage IV

Vascular Catheter Associated Infection	999.31	Complications of medical care, NEC, infection due to central venous catheter.
Mediastinitis after Coronary Artery Bypass Graft (CABG) surgery	519.2 and one of the following procedure codes: 36.10-36.19	Mediastinitis 36.10 - Aortocoronary bypass for heart revascularization, not otherwise specified 36.11 - (Aorto)coronary bypass of one coronary artery 36.12 - (Aorto)coronary bypass of two coronary arteries 36.13 - (Aorto)coronary bypass of three coronary arteries 36.14 - (Aorto)coronary bypass of four or more coronary arteries 36.15 - Single internal mammary-coronary artery bypass 36.16 - Double internal mammary-coronary artery bypass 36.17 - Abdominal-coronary artery bypass 36.19 - Other bypass anastomosis for heart revascularization
Hospital – Acquired Injuries – fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994)	Fracture code range Dislocation code range Intracranial injury code range Crushing injury code range Burns code range Other and unspecified effects of external causes code range
Manifestations of Poor Glycemic Control	249.10 -249.11 249.20 -249.21 250.10 – 250.13 250.20 – 250.23 251.0	Secondary Diabetes with Ketoacidosis Secondary Diabetes with Hyperosmolarity Diabetic Ketoacidosis Nonketotic Hyperosmolar Coma Hypoglycemic Coma
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 or 998.59 and one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.83, 81.83, 81.85	Infection and inflammatory reaction due to other orthopedic device and implant graft. Other postoperative infection 81.01 – Atlas-axis fusion 81.02 – Other cervical fusion anterior 81.03 – Other cervical fusion posterior 81.04 – Dorsal/dorsolum fusion anterior 81.05 – Dorsal/dorsolum fusion posterior 81.06 – Lumbar/lumbosac fusion anterior 81.07 – Lumbar/lumbosac fusion lateral 81.08 – Lumbar/lumbosac fusion posterior 81.23 – Arthrodesis of shoulder 81.24 – Arthrodesis of elbow 81.31 – Refusion of atlas-axis 81.32 – Refusion of other cervical spine anterior 81.33 – Refusion of other cervical spine posterior 81.34 – Refusion of dorsal spine anterior

		81.35 – Refusion of dorsal spine posterior 81.36 – Refusion of lumbar spine anterior 81.37 – Refusion of lumbar spine lateral 81.38 – Refusion of lumbar spine posterior 81.83 – Shoulder arthroplast NEC 81.85 – Elbow arthroplast NEC
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal diagnosis - 278.01, 998.59 and one of the following procedure codes: 44.38, 44.39 or 44.95	Morbid Obesity Other postoperative infection Laparoscopic gastroenterostomy, Other gastroenterostomy, Laparoscopic gastric restrictive procedure
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 415.19 453.40 453.41 453.42 and one of the following procedure codes: 00.85-0.87, 81.51-81.52, or 81.54	Iatrogenic pulmonary embolism and infarction Other pulmonary embolism and infarction Venous embolism and thrombosis of unspecified deep vessels of lower extremity Venous embolism and thrombosis of deep vessels of proximal lower extremity Venous embolism and thrombosis of deep vessels of distal lower extremity 00.85 – Resurfacing hip, total, acetabulum and femoral head. 00.86 – Resurfacing hip, partial, femoral head 00.87 – Resurfacing hip, partial, acetabulum 81.51 – Total hip replacement 81.52 – Partial hip replacement 81.54 – Total knee replacement

References

1. ICD-9 CM Official Guidelines for Coding and Reporting Pages 92-105. Accessed January 28, 2008 at <http://www.cdc.gov/nchs/datawh/ftp/ftpicd9/icdguide07.pdf>
2. CMS Hospital Acquired Conditions – Trauma Code Descriptions. Accessed November 1, 2007 at: <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalAcqConTraumaCodes.pdf>
3. National Quality Forum Updates Endorsement of Serious Medical Events in Healthcare, Accessed November 1, 2007 at: <http://www.qualityforum.org/pdf/news/prSeriousReportableEvents10-15-06.pdf>
4. National Quality Forum website, Accessed November 1, 2007 at: <http://www.qualityforum.org/projects/completed/sre/>
5. Federal Register: August 22, 2007, (Volume 72, Number 162). Accessed November 1, 2007 at - <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-3820.htm>. Pages 47200-47218

6. Federal Register: October 10, 2007 (Volume 72, Number 195) –Corrections to August 22, 2007; Accessed November 1, 2007 at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-4875.htm>
7. Federal Register, November 23, 2007 (Volume 72, Number 225). Accessed January 2, 2008 at: http://www.cms.hhs.gov/HospitalAcqCond/downloads/HAC_&_POA_Final_FRN_2007-11-23.pdf
8. MLN Matters MM5499 Revised, Effective October 1, 2007,; Accessed January 2, 2008 at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf>
9. CMS – Present on Admission Overview; Statute/Regulations/Program Instructions; Affected Hospitals; Reporting; Coding; Hospital Acquired Conditions Accessed January 2, 2008 at <http://www.cms.hhs.gov/HospitalAcqCond/>
10. The Leapfrog Group – www.leapfroggroup.org/for_hospitals/leapfrog_hospital_quality_and_safety_survey
11. American Medical Association. Current Procedural Terminology (CPT) ©2007.
12. CMS –Hospital Acquired Conditions Fact Sheet. Accessed January 15, 2008 at: http://www.cms.hhs.gov/HospitalAcqCond/Downloads/poa_fact_sheet.pdf
13. Major complication or co-morbidity (MCC) and complication or co-morbidity (CC) lists can be viewed online at <http://www.codingbooks.com/pdf/ccexclusions.pdf>
14. Norton E., Ann Surg. 2007 Apr;245(4):526-32.
15. Michaels RK, et., AORN J. 2006 May;83(5):1115-8, 1121-2.
16. Seiden, SC and Barah, P, Arch Surg. 2006 Sep;141(9):931-9.
17. *Kwaan MR* et. al. ,Arch Surg. 2006 Apr;141(4):353-7.
18. CMS Regulation No. CMS -1390-P “Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009”; Published 4/30/08; Accessed August 13, 2008 at: <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS1209719&intNumPerPage=10>
19. Federal Register, Volume 73, No.161, Tuesday, August 19, 2008 /Rules and Regulations, pages 48483-48532. Accessed August 19, 2008 at: <http://edocket.access.gpo.gov/2008/E8-17914.htm>

Policy History/Updates

Date	Change/Update
05/06/2009	Updated format. No policy changes
10/01/2008	Policy effective date for CIGNA HealthCare and former Great-West Healthcare network.
08/29/2008	Updated to include 4 additional conditions
04/15/2008	Notification date of policy for CIGNA HealthCare and former Great-West Healthcare network.

“CIGNA” and the “Tree of Life” logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. and Great-West Healthcare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

Connecticut General Life Insurance Company has acquired the business of Great-West Healthcare from Great-West Life & Annuity Insurance Company (GWLA). Certain products continue to be provided by GWLA (Life, Accident and Disability, and Excess Loss). GWLA is not licensed to do business in New York. In New York, these products are sold by GWLA's subsidiary, First Great-West Life & Annuity Insurance Company, White Plains, N.Y.