

2021



**HEALTH CARE
PROFESSIONALS
PROVIDER MANUAL**

MEDICARE ADVANTAGE



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Introduction and New 2021 Plan Offerings

Thank you for participating with Cigna Medicare Advantage! This provider manual has been created to assist you and your office staff in partnering with us to help improve our customer's health and wellbeing. It contains important information concerning our policies and procedures including claims payment and submission requirements, prior authorization and referral requirements and other helpful information. It also serves as an extension of your network participation agreement in which all providers are required to comply with it.

This manual replaces and supersedes all other prior versions. To the extent there is any inconsistency between the terms of this manual and your network participation agreement, the terms of your network participation agreement will control. This manual is also intended to help providers more effectively do business with Cigna Medicare, so please make time to review it carefully.

You will notice new product offerings for 2021, and we are excited to introduce new plans in select markets. This manual will guide you through the differences in the HMO or PPO plans that your customer's may have.

The table below outlines things you need to know as you navigate through this manual.

Topic	What you need to know
Referrals	<ul style="list-style-type: none">• HMO: Referral required in select plans• PPO: No referral required
Quick Reference Guide	Highlights Key Contacts
Local Network Information	<ul style="list-style-type: none">• Regional Product Maps are located in the Appendix.• Market-specific contacts are located throughout the Provider Manual depending on the topic.• Customer Identification Cards provide high-level product/network information. Remember to contact the phone numbers on the card for assistance and follow guidance in order to verify eligibility, referral/no referral and authorization guidance.

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Medicare Overview

Cigna contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage (MA) plans. Customers are able to select one of several plans offered based on their location, budget and health care needs.

	Health Maintenance Organization (HMO) Plans	Preferred Provider Organization (PPO) Plan
Selection of a Primary Care Physician (PCP)	<ul style="list-style-type: none"> Requires customers to select a PCP. Customers are allowed to select a different PCP at anytime. 	Not Required ; although encouraged to select a PCP from the point of enrollment and throughout their Cigna Medicare Advantage journey
Referrals to Specialists	<ul style="list-style-type: none"> Referral requirements are indicated on the customer's Cigna ID Card. Select service areas do not require the use of referrals. 	Not required.
Cigna ID Card	The customer's type of plan will be indicated at the top of the customer's Cigna Identification card. See the 2021 Example ID Cards section.	

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Key Contacts

KEY CONTACTS	
Behavioral Health/Substance Use Disorders	<p>Cigna Network (Please call for authorizations) Call: 1-866-780-8546 Fax: 1-866-949-4846</p>
Claims Processing	<p>Claims questions: 1-800-230-6138</p> <p>Electronic Claims may be submitted through:</p> <ul style="list-style-type: none"> • Change Healthcare/Availity (Payor ID: 63092 or 52192) • SSIGroup/Proxymed/Medassests/Zirmed/OfficeAlly/Gateway EDI (Payor ID: 63092) • Relay Health (Professional claims CPID: 2795 or 3839 Institutional claims CPID: 1556 or 1978) <p>Mail Paper Claims to: Cigna PO Box 981706 El Paso, TX 79998</p> <p>Mail Reconsideration Requests to: Cigna Reconsiderations PO Box 20002 Nashville, TN 37202</p>
Part C Appeals	<p>Appeals questions: 1-800-511-6943 Fax: 1-800-931-0149</p> <p>Mail Appeals to: Cigna Attn: Part C Appeals PO Box 24087 Nashville, TN 37202</p>
Coding and Documentation	<p>www.cigna.com/codingeducation</p>
Compliance	<p>To report potential fraud, waste or abuse please contact Cigna's Special Investigations Unit</p> <p>By mail: Cigna Attn: Special Investigations Unit PO Box 20002, Nashville, TN 37228</p> <p>By email: specialinvestigations@cigna.com Attn: Cigna Medicare Operations</p> <p>By phone: 1-800-667-7145</p>

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Council for Affordable Quality Healthcare (CAQH®)	https://proview.cagh.org
Dental Services	<p>DentaQuest: Call: 1-800-241-6554 or visit: https://dentaquest.com/</p> <p>Dental Allowance: Call: 1-866-213-7295 For questions concerning Supplemental Benefits, please call Provider Services Call: 1-800-230-6138</p>
Eligibility Verification / Co-Payment Information	<p>Customer Service: 1-800-668-3813 Provider Portal: https://www.hsconnectonline.com/login.aspx</p>
HSCConnect (Online Portal)	<p>Experience the ease of HSCConnect. Your online solution for referral entry and inquiry, inpatient authorization inquiry, eligibility verification, and claims payment review.</p> <p>Call: 1-866-952-7596 Email: HSConnecthelp@hsconnectonline.com </p> <p>To register for HSCConnect visit: https://www.hsconnectonline.com/login.aspx</p>
Outpatient Laboratory Services	Please visit the Provider Online Directory for a complete listing of participating outpatient laboratories
Prior Authorization (Non-Pharmacy)	<p>Prior Authorization must be obtained for the following services: Inpatient and Elective Admission Notification, Home Health Care, DME, and Outpatient Services.</p> <p>Prior Authorization can be obtained through HSCConnect Provider Portal: https://www.hsconnectonline.com/login.aspx or by calling Provider Customer Service at 1-800-230-6138.</p>
Prior Authorization High Tech Radiology, Diagnostic Cardiology, Radiation Therapy, Medical Oncology	Please see the Medicare Advantage Provider Quick Reference Guide here for additional information on submitting prior authorization requests to eviCore for outpatient, non-emergent high tech radiology and diagnostic cardiology, radiation therapy and medical oncology services
Pharmacy	<p>Prior Authorization Requests: Electronic: www.covermymeds.com (Preferred method) Forms: www.cigna.com/medicare/resources/drug-search Phone: 1-877-813-5595 Fax: 1-866-845-7267</p> <p>Formulary Website: www.cigna.com/medicare/part-d/drug-list-formulary</p>

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Provider Customer Service / Website	Provider Customer Service: 1-800-230-6138 Visit: medicareproviders.cigna.com
Supplemental Benefits	For questions concerning Supplemental Benefits, please call Provider Customer Service at 1-800-230-6138 www.superiorvision.com or www.hearingcaresolutions.com

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Eligibility

All participating providers are responsible for verifying a customer’s eligibility at each visit. Please note that customer data is subject to change. CMS retroactively terminates customers for various reasons. When this occurs, Cigna’s claim recovery unit will request a refund from the provider or offset the overpayment. The provider must then contact CMS Eligibility to determine the customer’s actual benefit coverage for the date of service in question.

Verify Customer Eligibility

Please note: Cigna should have the most up-to-date information that is available, however, Cigna’s eligibility information may not be completely accurate as CMS retroactively terminates customers for various reasons. You must call Cigna to verify eligibility when the customer cannot present identification or does not appear on your monthly eligibility list.


The table below outlines **three** methods to verify customer eligibility.

If verifying customer eligibility via:	Then:
Provider Services	Call 1-800-230-6138 Hours Monday-Friday: 8 am - 5 pm CST
HS Connect (Provider Portal) Description: This provider portal allows our providers to verify customer eligibility online. See the Experience of HS Connect section for further instruction.	Access HSConnect or www.hsconnectonline.com
Customer’s Cigna Identification Card Description: Each customer is provided with an individual customer Cigna identification card indicating type of eligibility. Changes do occur with eligibility, the card alone does not guarantee the customer is eligible and may be less accurate than contacting Cigna via phone or HSConnect .	Review the customer’s Cigna identification card to determine the following: <ul style="list-style-type: none"> • Plan code • Name of PCP (HMO only) • Copayment • Effective date See the 2021 Example ID Cards section below.

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2021 Example ID Cards

MA

		<Plan Name> <Plan Type>	
Name	<Customer Full Name>	<Contract/PBP/segment>	
ID	<Customer ID>		
Health Plan	(80840)		
[Effective Date	<Effective Date>]		
PCP	<PCP Name>	Part B Drugs	
PCP Phone	<Phone Number>	[RxBIN	<XXXXXXXX>
PCP Network	<Network>	[RxPCN	<XXXXXXXX>
		[RxGRP	<XXXXXXXX>
[No Referral Required]		COPAYS	
PCP	<\$xx>	Specialist	<\$xx>
Emergency	<\$xx>	Urgent Care	<\$xx>

INT_21_89709_C

This card is used for non-TrueChoice MA Only plans.

This card does not guarantee coverage or payment.
<barcode>


[Services may require [a referral or] [an] authorization by the Health Plan.]
[Medicare limiting charges apply.]

[Customer Service <--Toll Free Number ---> (TTY 711)]

[Provider Services <Phone Number>]
[Authorization][Referral] <Phone Number>
[Provider Medical Claims <Address>]
[Dental Services <Phone Number>]
[Provider Dental Claims <Address>]
[Pharmacy Help Desk <Phone Number>]

[<URL>]

MAPD

		<Plan Name> <Plan Type>	
Name	<Customer Full Name>	<Contract/PBP/segment>	
ID	<Customer ID>		
Health Plan	(80840)	[MedicareRx] <small>Prescription Drug Coverage X</small>	
[Effective Date	<Effective Date>]		
PCP	<PCP Name>		
PCP Phone	<Phone Number>	RxBIN	<XXXXXXXX>
PCP Network	<Network>	RxPCN	<XXXXXXXX>
		RxGRP	<XXXXXXXX>
[No Referral Required]		COPAYS	
PCP	<\$xx>	Specialist	<\$xx>
Emergency	<\$xx>	Urgent Care	<\$xx>

INT_21_89712_C

This card is used for all plans except True Choice, EGWP, Leon and Arizona plans.

This card does not guarantee coverage or payment.
<barcode>

[Services may require [a referral or] [an] authorization by the Health Plan.]
[Medicare limiting charges apply.]

[Customer Service <--Toll Free Number ---> (TTY 711)]

[Provider Services <Phone Number>]
[Authorization][Referral] <Phone Number>
[Provider Medical Claims <Address>]
[Pharmacy Help Desk <Phone Number>]
[Pharmacy Claims <Address>]
[Dental Services <Phone Number>]
[Provider Dental Claims <Address>]

[<URL>]

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Exchange of Electronic Data

Information Protection Requirements and Guidance

Cigna follows all applicable laws, rules, and regulations regarding the electronic transmittal and reception of customer and provider information. As such, if an electronic connection is made to facilitate such data transfer, all applicable laws must be followed. At all times, a provider must be able to track disclosures, provide details of data protections, and respond to requests made by Cigna regarding information protection.

Cigna will engage with a provider's staff to appropriately implement the connection. Any files placed for receipt by provider staff must be downloaded in 24 hours, as all data is deleted on a fixed schedule. If the files are unable to be downloaded, then alternate arrangements for retransmission must be made. The provider and provider's staff must work collaboratively with Cigna to ensure information is adequately protected and secure during transmission.

Experience the Ease of HSConnect

- View customer eligibility
- Create referrals and pre-certifications
- Search authorizations
- Search claims

Need More Help?

Contact the HSConnect Help Line: **1-866-952-7596 option 2** or e-mail
ail HSConnectHelp@HSConnectOnline.com

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Vendor-Specific Networks

Cigna may elect to offer or obtain certain Covered Services exclusively through arrangements with national or regional vendor networks. It is important for participating providers to be aware of these vendor-specific networks to avoid potential claims issues and customer confusion.

Cigna currently utilizes **two vendor-specific networks**: (1) Hearing Care Solutions (for routine hearing-related benefits and supplies) and (2) Superior Vision (for routine vision services and supplies in all markets except Alabama, Southern Mississippi and Northern Florida (Panhandle) and medical vision coverage in our Maryland, Delaware, District of Columbia, Pennsylvania, New Jersey, Northern Virginia and Kansas City markets).

In our HMO plans, these hearing and vision services may be covered only when they are supplied by providers that participate in the Hearing Care Solutions or Superior Vision networks. In our PPO plans, they may be covered at in-network benefit and cost-sharing levels only when they are supplied by providers that participate in the Hearing Care Solutions or Superior Vision networks. Providers are encouraged to call the customer service number on the customer's ID card with any questions around services that may or may not be covered.

Providers should inform customers whether they participate in either of these vendor-specific networks before providing any related services. To explore participating in these vendor-specific networks, please contact your Network Operations representative or visit www.superiorvision.com or www.hearingcaresolutions.com

CLIA Certification Required for Laboratory Services

CMS regulates all laboratory testing (except research) performed on humans in the United States through the Clinical Laboratory Improvement Amendments (CLIA). CLIA was established to help ensure the accuracy and reliability of customer test results. CLIA applies to all laboratories – including laboratories operating within physician offices and provider facilities – that examine “materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.” CLIA regulatory requirements vary according to the kind of test(s) each laboratory conducts. All healthcare providers that meet the definition of a “Laboratory” under the CLIA statutes and regulations must obtain an appropriate CLIA certificate prior to conducting customer testing.

Laboratory service providers seeking reimbursement from Cigna must ensure that the appropriate CLIA information is submitted with their claims using the correct loops, segments, and associated line level qualifiers. Please refer to the ANSI X12N 837 Professional Claim guidelines and the Medicare Claims Processing Manual Chapters 1, 16, 26 and 35 for more information.

Cigna will not reimburse any claim submitted by a provider that cannot demonstrate appropriate CLIA certification. Cigna also reserves the rights to deny claims for Covered laboratory services that do not contain appropriate CLIA information and to apply claim line edits if the lab certification level does not support the billed service code.

Additional information regarding CLIA may be found at the following website:
<https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html>

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High-Tech Radiology, Diagnostic Cardiology, Radiation Therapy & Medical Oncology Management Programs

Program Overview

Cigna works with eviCore Healthcare to manage prior authorization of outpatient, non-emergency, high-tech radiology and diagnostic cardiology services, radiation therapy and medical oncology (excludes Part D coverage) in order to provide high-quality, cost-effective services to Cigna customers. Services performed without pre-certification may be denied for payment, and you may not seek reimbursement from customers.

Important: It is the responsibility of the performing facility or provider to confirm prior authorization has been obtained and approved prior to service(s) being performed.

Clinical Guidelines can be located by visiting: <https://www.evicore.com/cigna> A list of Cigna **CPT Codes** that require pre-certification can be located by visiting: www.eviCore.com/healthplan/healthspring

Please see the [Medicare Advantage Provider Quick Reference Guide](#) for information on submitting pre-certification requests to eviCore.

Credentialing

All practitioner and organizational applicants to Cigna must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. These requirements are the same whether the provider is credentialed by Cigna or another entity delegated by Cigna to credential MA network providers. Cigna's credentialing standards and processes are designed to comply with CMS regulations and applicable law.

Cigna does not discriminate in terms of participation, reimbursement, or based on the population of customers serviced, against any health care professional who is acting within the scope of his or her license or certification under state law. In order to participate in the Cigna network, providers undergo a screening process before a contract can be extended to them. Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied participation with the plan. No provider can be assigned a health plan effective date, be included in a provider directory, or have customers assigned without completing the credentialing and peer review process. All providers who have been initially approved for participation are required to recredential at least once every three years (i.e., every 36 months) in order to maintain participation status.

Practitioner and Organizational Selection Criteria

Practitioner

Cigna utilizes specific selection criteria to ensure that practitioners who apply to participate meet basic credentialing and contracting standards. At minimum these include, but are not limited to:

- Holds appropriate, current and unrestricted licensure in the state of practice as required by state and federal entities.

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- Holds a current, valid, and unrestricted federal DEA and state controlled substance certificate as applicable.
- Is board-certified or has completed appropriate and verifiable training in the requested practice specialty.
- Physicians and practitioners must have and maintain malpractice insurance of at least \$1,000,000 per incident and \$3,000,000 aggregate, unless state and/or federal laws require otherwise.
- Has a National Provider Identification number.
- Has not been excluded, suspended, precluded and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.
- Is not currently opted out of Medicare.
- Has admitting privileges as applicable.

Application Process

1. Complete and submit a Network Interest Form to Network Operations. Network Operations will review each practitioner for eligibility, current contract status and network need. If approved for a contract, Network Operations will send a credentialing packet that will include a contract (unless a current group agreement already exists) and a W-9 form that must be completed and signed. If the provider utilizes the Council for Affordable Quality HealthCare (CAQH) Proview system, practitioner must ensure that all information contained in their CAQH profile is current, including the attestation signature date, and that they have given Cigna permission to access the CAQH information. If the provider does not utilize CAQH, the provider may contact CAQH at **1-888-599-1771** to request a paper application. An application form may also be included in the credentialing/contract packet and must be completed and returned by the practitioner along with the contract.
2. All credentialing applications must contain the following information to be considered complete:
 - a. All current and active state medical licenses, DEA certificate(s), and state controlled substance certificate as applicable.
 - b. Evidence of current malpractice insurance that includes the effective and expiration dates of the policy and term limits.
 - c. Five years of work history documented in a month/year format either on the application or on a current curriculum vitae. Explanations are required for any gaps exceeding six (6) months.
 - d. If any of the Professional Disclosure questions are answered 'yes' on the application, supply sufficient additional information and explanations.
 - e. Provide appropriate clinical detail for all malpractice cases that are pending, or resulted in a settlement or other financial payment within the last 5 years.
 - f. If a physician, include current and complete hospital affiliation information on the application. If no hospital admitting privileges and the specialty warrants hospital

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privileges, a letter detailing the alternate coverage arrangement(s) or the name of the alternate admitting physician must be provided.

- g. Application must be signed and dated.
3. Once a completed and signed contract/credentialing packet has been received, Network Operations will submit a request to Credentialing to start the credentialing verification process and forward any application information that was received.
4. Credentialing logs all received applications and begins the verification process. Applications are processed by the date that they are received unless Network Operations indicates that there is a specific customer or network need that requires more expedited processing.
5. Once the credentialing process is complete, Network Operations will send you a welcome letter that contains your participation effective date. Be advised that any requests for payment for services rendered to a Cigna customer prior to your participating effective date shall be denied.

Practitioner Rights

- Right to review information obtained from any outside source to evaluate their credentialing application with the exception of references, recommendations or other peer-review protected information. The provider may submit a written request to review his/ her file information at least thirty days in advance at which time the Plan will establish a time for the provider to view the information at the plan's offices.
- Right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the practitioner. In instances where there is a substantial discrepancy in the information, Credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within thirty (30) days of notification.
- Right to be informed of the status of their application upon request. A provider may request the status of the application by calling the Provider Customer Service Center for assistance. Cigna will respond within two business days for telephonic requests and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status. Written/electronic requests will be responded to within 15 business days.

Organizational Provider

When assessing organizational providers for participation, Cigna utilizes the following criteria:

- Must be in good standing with all state and federal regulatory bodies.
- Has been reviewed and approved by an accrediting body deemed by Medicare or recognized by Cigna.
- If not accredited, must provide a copy of a survey conducted by a state or federal agency within the 36 months prior to app submission which contains the corrective action plan

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for any identified deficiencies and proof of state/federal acceptance of the corrective action and/or current compliance with Medicare/Medicaid program requirements.

- Organizations that are not accredited or have not been surveyed by a state or federal regulatory body within the last 36 months may be subject to a health plan conducted site audit.
- Maintains current professional and general liability insurance as applicable.
- Has not been excluded, precluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.
- Is currently enrolled in an active status with Medicare, including any sub-entities and/or additional National Provider Identifier (NPI) numbers the organization may utilize

Organizational Provider Application and Requirements

- A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
- If responding, "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.
- Copies of all applicable state and federal licenses (i.e. facility license, DEA, CLIA certificate, Pharmacy license, etc.).
- Proof of current professional and general liability insurance as applicable.
- Proof of Medicare enrollment per site if submitting multiple locations
- If accredited, proof of current accreditation.
 - **Note:** Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.
- If not accredited, a copy of any state or CMS site surveys that occurred within the last three years including evidence that the organization successfully remediated any deficiencies identified during the survey.

Credentialing and Recredentialing Process

Cigna's Credentialing Department conducts primary and secondary source verification of the applicant's licensure, education and/ or board certification, privileges, lack of sanctions or other disciplinary action, Medicare status and malpractice history by querying the National Practitioner Data Bank. The credentialing process generally takes up to ninety days to complete, but can in some instances take longer. Once credentialing has been completed and the applicant has been approved, Network Operations will notify the practitioner in writing of their participation effective date.

To maintain participating status, all practitioners are required to recredential at least every three (3) years (i.e., every 36 months). Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners who do not have a current CAQH profile or do not utilize CAQH will be notified of the need to submit recredentialing information in advance of their three-year credentialing anniversary date. Three (3) separate attempts will be made to obtain the required information via mail, fax, email, or telephonic request. Practitioners who fail

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to return recredentialing information at least 45 days prior to their recredentialing anniversary date will be notified in writing of their termination from the network.

Credentialing Committee and Peer Review Process

All initial applicants and recredentialed providers are subject to a peer review process prior to approval or re-approval as a Participating Provider. Providers who meet all of the acceptance criteria may be approved by the Medical Director. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of contracted primary care and specialty providers, and has the authority to approve or deny an appointment status to a provider. All required credentialing information and verifications must be completed and be less than one hundred eighty (180) days old at the time of presentation to the Medical Director or the Credentialing Committee for approval.

Office Site Evaluations

Office site surveys and medical record keeping practice reviews may be required when it is deemed necessary as a result of a customer complaint, quality of care issue, and/or as otherwise mandated by state regulations. Practitioner offices will be evaluated in the following categories:

- Physical appearance and accessibility.
- Customer safety and risk management.
- Medical record management and security of information.
- Appointment availability.

Providers who fail to pass the area of the site visit specific to the complaint or who score less than 80% on the site evaluation overall will be required to submit a corrective action plan and make corrections to meet the minimum compliance score. A follow up site evaluation will be done within sixty (60) days of the initial site visit if necessary to ensure that the corrective action plan has been implemented.

Accreditation for DME, Orthotics, and Prosthetic Providers

All Durable Medical Equipment (DME) and Orthotics and Prosthetic providers are required by Medicare to be accredited by one of the 10 national accreditation organizations. The most current listing of these organizations can be found at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizationsCMB.pdf>

Pharmacies that provide Durable Medical Equipment but are exempt from the accreditation requirement under Public Law #111-148 which amended title XVIII of the Social Security Act must provide the following information with their initial application:

- Evidence the pharmacy has been enrolled with Medicare as a supplier of Durable Medical Equipment, prosthetics, orthotics, and suppliers and has been issued a provider number for at least five (5) years.
- An attestation that the pharmacy has met all criteria under the above referenced amendment.

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Non-discrimination in the Decision-Making Process

Cigna's credentialing program is compliant with all guidelines from the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), and state regulations as applicable. Through the universal application of specific assessment criteria, Cigna ensures fair and impartial decision-making in the credentialing process, and does not make credentialing decisions based on an applicant's race, gender, age, ethnic origin, nationality, sexual orientation, gender identity or due to the type of customers or procedures in which the provider specializes.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of their participating provider HMO, PPO, or HMO/PPO network effective date(s). Providers are advised to not see Cigna customers until they receive notification of their HMO, PPO, or HMO/PPO participation and effective date(s). Applicants who are denied by the Credentialing Committee will be notified in writing within sixty (60) days of the decision detailing the reason(s) for the denial.

Appeals Process and Notification of Authorities

If a provider's participation is limited, suspended, or terminated, the provider is notified in writing within sixty (60) days of the decision. Notification will include: a) the reasons for the action, b) outline of the appeals process or options available to the provider, and c) the time limits for submitting an appeal. All appeals will be reviewed by a panel of the provider's peers. When termination or suspension is the result of quality deficiencies, the appropriate state and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and recredentialing process is considered confidential and is handled and stored in a confidential and secure manner as required by law and regulatory agencies. Confidential practitioner credentialing and recredentialing information will not be disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing Monitoring

Cigna conducts routine, ongoing monitoring of license sanctions, Medicare/Medicaid sanctions, OIG Exclusions, CMS Preclusion and the CMS Opt Out list between credentialing cycles. Participating providers who are identified as having been sanctioned, are the subject of a complaint review, or are under investigation for or have been convicted of fraud, waste, or abuse are subject to review by the Medical Director or the Credentialing Committee who may elect to limit, restrict or terminate participation. Any provider whose license has been revoked or has been excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program or who has opted out of Medicare will be immediately and automatically terminated from the plan.

CMS Preclusion List

CMS publishes a Preclusion List that lists providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs

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furnished or prescribed to Medicare beneficiaries.

What is the impact?

CMS makes the Preclusion List available to Part D sponsors and the MA plans on a monthly basis. The preclusion list requirements are:

- Part D sponsors must reject pharmacy claims (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List.
- MA plans must deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.
- Cigna will terminate the network participation agreement of providers on the preclusion list.

Who is on the list?

Individuals or entities who meet the following criteria:

- Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

Are providers notified when they are placed on the Preclusion List?

Yes. CMS sends an email and letter to the provider or entity in advance of their inclusion on the Preclusion List. The email and letter are sent to the Provider Enrollment Chain and Ownership System (PECOS) address or National Plan and Provider Enumeration System (NPES) mailing address. The letter includes the reason for the preclusion, the effective date of the preclusion, and applicable rights to appeal. For more information on the preclusion list, visit: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Preclusion-List>

Provider Directory and Requirements

To be included in Provider Directories or any other customer communications, providers must be fully credentialed and contracted. Directory specialty designations must be commensurate with the education, training, board certification, and specialty (ies) verified and approved by the credentialing process. Any requests for changes or updates to the specialty information in the directory will only be approved once validated through the credentialing process.

Requirements

CMS requires all Medicare Advantage Organizations (MAOs) to outreach to contracted providers on a quarterly basis in order to verify provider's demographic data published in the Cigna provider directories. CMS also requires MAOs to update the provider directories within 30 days of receipt of new or revised demographic information.

Cigna utilizes the Council for Affordable Quality Healthcare (CAQH) to make quarterly outreaches to contracted practitioners. For all other provider types, Cigna reaches out via mail – providing instructions on how to complete the quarterly attestation process.

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If you move locations, change phone numbers or any other demographic information, update the information within 7 days of the change. Please do not wait for the quarterly update to make such a change. If you are a practitioner, visit the CAQH site to make the updates. If you are a facility / ancillary provider, submit your changes by visiting chsproviderdatavalidation.com/.

As a contracted provider you are required to comply with the outreach request and supply updated information within the allotted timeframe. Failure to provide a response to the quarterly outreach will result in suppression from our provider directory or other action. Suppression from the directory means that customers and other providers will not be able to view you as a participating provider in the Cigna networks. If you were removed from the directory and you are a practitioner, visit the CAQH site to update/attest to your demographic information. If you are a facility / ancillary, submit your attestation by visiting chsproviderdatavalidation.com/.

The accuracy of our directories directly impacts the customers we both serve. We take this compliance requirement very seriously and expect that you will cooperate fully with the attestation and validation process. If a provider fails to cooperate, we will take action, including suppression and potentially termination from participation from our Medicare Advantage plans.

Additional Quarterly Provider Directory Data Attestation Details

Provider Termination

Cigna is required to make good faith efforts to provide at least 30 calendar days advance written notice to impacted customers when a provider is being terminated or leaving the network. Impacted customers are those who are seen on a regular basis by the provider, have scheduled services with the provider or have recently received treatment or a service from the provider (within the past 90 calendar days). Providers must provide advanced written notice (timeframe varies based on the provider services agreement) to Cigna prior to terming their agreement or leaving the network (retiring, office closure, moving out of area, etc.). Reference your participating provider agreement for termination notification requirements.

Plan Notification Requirements for Providers

Participating providers must provide written notice to Cigna no less than 90 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

The following is a list of changes that must be reported to Cigna by contacting your Network Operations Representative or Customer Service:

- Practice address.
- Billing address.
- Fax or telephone number.
- Hospital affiliations.
- Practice name.
- Providers joining or leaving the practice (including retirement or death).

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- Provider taking a leave of absence.
- Practice mergers and/or acquisitions.

Practitioners

Cigna will receive any updates made within your CAQH ProView profile to update our provider directories. Your attestation must be current in order to prevent further outreach from the plan. To submit your directory changes in CAQH ProView, you will need to take the following steps:

1. Log in to your **CAQH ProView** profile at <https://proview.caqh.org>.

Note: New users can go to <https://proview.caqh.org> to create a secure account. Review CAQH's step-by-step videos and user guides before you start.
2. Navigate to the **Practice Locations** section to update your profile.
3. **Review** and **update** all the required fields to make sure customers can find you.
 - a. Ensure you indicate current **practice name, suite number**, whether you are **accepting new customers**, etc., so the most accurate and up-to-date information is included in directories.
 - b. **Avoid** duplicate addresses. If one location (e.g., a medical complex) houses multiple practices, be sure to include suite numbers to distinguish the addresses.
 - c. Describe your practice affiliation for each location so health plans can determine whether it belongs in their directories.
 - d. Indicate the health plans you accept at the practice location level, since health plan participation may vary by location. You are not being asked to specify networks/products for a health plan at this time.
 - e. Share the phone number customers can call to make an appointment in the **Office Phone Number** field.
4. **Review** and **Attest** to your CAQH ProView profile.
 - a. Address any **errors** by navigating to the corresponding section and making updates.
 - b. Click **Attest** once you confirm that the status bar at the top of your profile, **Profile Data**, shows the word **Complete** in green.
 - c. If you have any questions, use the **Live Chat** function while you are logged into CAQH ProView or call the CAQH ProView Help Desk at **1-888-599-1771**.
 - d. You can use this single process through **CAQH ProView** to communication changes about your practice and professional information with multiple health plans.

Facility / Ancillary Providers

Written Notice/Provider Data Validation Website: If you are a facility or ancillary provider (or do not participate with CAQH), Cigna will send a quarterly notice to each service location for a provider. Providers receiving this notification are expected to visit the Cigna Provider Data Validation website at chsproviderdatavalidation.com/ to validate the information currently displayed within the provider directory through the following steps:

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1. Login to the site using the individual provider **NPI number** and **username** contained in the notification.
2. Review and update all the required fields to make sure customers can find you.
 - a. Ensure you indicate current **practice name, suite number**, whether you are **accepting new customers**, etc., so the most accurate and up-to-date information is included in directories.
 - b. **Avoid** duplicate addresses. If one location (e.g., a medical complex) houses multiple practices, be sure to include suite numbers to distinguish the addresses.
 - c. Describe your **practice affiliation** for each location so health plans can determine whether it belongs in their directories.
 - d. Indicate the **health plans** you accept at the practice location level, since health plan participation may vary by location. You are not being asked to specify networks/products for a health plan at this time.
 - e. Share the phone number customers can call to make an appointment in the **Office Phone Number** field.
3. If the information is correct and no changes are needed, check the **attestation** boxes verifying the information is accurate.
4. A **Thank You** page will appear once changes have been submitted.
5. **Log out** once all changes have been submitted.

Cigna monitors the accuracy of its provider directory information in part by conducting direct phone calls to provider offices. The Centers for Medicare and Medicaid Services (CMS), may also contact provider offices to validate this information. Providers must ensure all office staff are trained to answer questions about online directory information, network participation and the provider's access and availability.

Remember: Submit any changes in a timely manner so we can ensure customers are able to find you. Failure to respond to our quarterly outreach requests may result in suppression of your information in our online directory. This means customers will not see you listed as a participating provider in our network.

Continuity of Care

Cigna's policy is to provide for continuity and coordination of care with medical practitioners treating the same customer, and coordination between medical and behavioral health services. When a provider leaves Cigna's network and a customer is in an active course of treatment, our Health Services staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, customers undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. Customers in their second or third trimester of pregnancy have access to the exiting provider through the postpartum period.

An **active course of treatment** is when a customer has regular visits with the provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or

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other treatment or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition). The postpartum period begins immediately after childbirth and extends for approximately six weeks.

Providers must agree to:

- Continue treatment for an appropriate period of time (based on transition plan goals).
- Share information about the treatment plan with the organization.
- Continue to follow Cigna's UM policies and procedures.
- Charge only the required copayment.

Cigna will work to transition a customer into care with a participating physician or other provider within Cigna's network, but is not required to provide continued access in the following circumstances:

- If the provider is unwilling to continue to treat the customer or accept the organization's payment or other terms.
- If the customer is assigned to a provider group, rather than to an individual provider, and has continued access to practitioners in the contracted group.
- If the contract is terminated based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.).

Cigna also recognizes that new customers join our health plan and may have already begun treatment with a provider who is not in Cigna's network. Under these circumstances, Cigna will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the customer a transition period of up to 90 calendar days to complete the current course of treatment.

Cigna will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, Specialist referrals, and any other on-going services) initiated prior to a new customer's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the customer and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please review our Health Services section of this manual for contact information for Case Management Services.

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Billing

Claims

Claims Submission

While Cigna prefers electronic submission of claims, both electronic and paper claims are accepted. If you are interested in submitting claims electronically (EDI), contact Cigna Provider Services for assistance at **1-800-230-6138**.

Electronic claims may be submitted through:

- Change Healthcare / Availity (Payer ID: 63092 or 52192)
- SSI Group /Proxymed/Medassets/Zirmed/Office Ally/Gateway EDI (Payer ID: 63092)
- Relay Health (Professional claims CPID: 2795 or 3839 Institutional claims CPID: 1556 or 1978)

Electronic Remittance Advice (ERA)/Electronic Funds Transfer (EFT) Enrollment Process

Electronic payment options help save time and simplify reconciliation. Through our partnership with Change Healthcare, we are pleased to continue offering simpler, more efficient ePayment Solutions to help you maximize revenue and profit, reduce costs and errors and increase payment efficiency. To learn more about the EFT service offering, access Change Healthcare's Payer List to see all available EFT-enabled payers:

1. Access the Enrollment forms for **ERA** and **EFT** via www.changehealthcare.com/support/customer-resources/enrollment-services.
2. Select **ERA Enrollment Forms** to receive ERA files.
 - a. In Section **ERA Payer Enrollment Forms** select **institutional** or **professional** and input **52192** in the search bar.
 - b. Click **Enter**. The Cigna form will display.
3. **Click** the form and complete. You can send directly via email to Change Healthcare on the bottom of the form.
4. Select **EFT Enrollment Forms** to receive payments electronically.
5. To set-up an EFT or change an existing EFT banking or payer select the **EPayment Request Forms**.
6. Complete the form per instructions and email to eftenrollment@changehealthcare.com or fax to **615-238-9615**.
7. To change a contact on an existing EFT select 'Epayment Contact Change Form'
 - a. Complete the form.
 - b. Email is to eftenrollment@changehealthcare.com or fax to **615-238-9615**.

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ERA/EFT Support (after enrollment)

1. **EFT support** requests after enrollment, contact **866-506-2830 Option 2**
2. **ERA/Claims support** requests after enrollment, contact **866-742-4355 Option 1**
3. If a Provider is setup for EFT they can view electronic payments and electronic remittances (ERA) via the Payment Manager portal:
<https://cda.changehealthcare.com/Portal/>
 - a. To request a login, contact **866-506-2830**
 - b. To access the user guide to the Payment Manager portal:
https://cda.changehealthcare.com/ext/Manuals/Payment_Manager_SVP_NEW_GUI_4.2.pdf
4. If not setup for EFT or only set up for ERA, contact Change HealthCare at **866-369-8805** to request a paid version of Payment Manager.
5. Alternately, if a Provider is not set up to receive EFTs, they may request access to the Vision Tool by submitting an ON 24/7 request to view claims, EFTs or ERAs.
 - a. To submit a request through CHC ON 24/7: <https://client-support.changehealthcare.com>
6. For additional support, view the Provider Quick Reference User Guide at [Changehealthcare.com](https://changehealthcare.com) > Support > [Enrollment](#) > Provider Quick Reference User Guide

Paper Claims Submission

Cigna
Attn: Claims
PO Box 981706
El Paso, TX 79998

Supporting claim documents (i.e. medical records, itemized bills, EOBs, etc. should be faxed to **615-401-4642** or mailed to:

Cigna
Attn: Claims Intake
PO Box 20002
Nashville, TN 37228

Timely Filing

As a Cigna Participating Provider, you have agreed to submit all claims within the timeframes outlined in your provider agreement.

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Claim Format

The standard CMS required forms and data elements can be found in the CMS claims processing manual located at <https://www.cms.gov/manuals/downloads/clm104c12.pdf>. Appropriate forms and data elements must be present for a claim to be considered a clean claim.

Cigna can only pay claims which are submitted accurately. The provider is always responsible for accurate claims submissions. While Cigna will attempt to inform the provider of claims errors, responsibility for claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same customer by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties may bill and be paid without regard to their customer in the same group.

Claim Format Standards

Cigna pays clean claims according to contractual requirements and the Centers for Medicare and Medicaid Services (CMS) guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety and otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. A defect or impropriety includes, without limitation, lack of data fields required by Cigna or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of Cigna, the claim is not considered clean.

Offsetting

Contracted providers will be informed of any overpayments or other payments you may owe us. You will have thirty (30) days from receipt of our repayment demand to refund such amounts to us. If you have not refunded us within the thirty (30) day recovery period, we will offset the recovery amounts identified in the initial repayment demand, or in accordance with the terms of your agreement.

Pricing

Original Medicare typically has market-adjusted prices by code (i.e. CPT or HCPCS) for services that Original Medicare covers. However, there are occasions where Cigna offers a covered benefit for which Medicare has no pricing. In order to expedite claims processing and payment in these situations, Cigna will determine the price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. Cigna requests that you make every effort to submit claims with standard coding, failure to do so could delay processing. As described in this Manual and/or your agreement, you retain your rights to submit a Claim Disputes/Reconsideration you feel the reimbursement was incorrect. In the instance of an inpatient admission downgrade to

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observation, please submit an itemized bill including CPT and or HCPCS codes in order to expedite processing.

Claims Encounter Data

Claim encounter data are providers who are being paid under capitation and must submit claims in order to capture encounter data as required per your Cigna Provider Agreement.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the provider after coverage and payment have been determined by Cigna. The statement provides a detailed description of how the claim was processed.

Prompt Payment

Cigna will pay Participating Providers in accord with the applicable provisions of their agreement with Cigna.

Non-Payment/Claim Denial

Any denials of coverage or non-payment for services by Cigna will be addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed per each billed line if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP/RA. Per your contract, the customer may not be billed for Covered Services denied by Cigna. In some instances, providing the needed information may reverse the denial (i.e. referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the customer, or the services are not covered, the EOP/RA will alert you to this and you may bill the customer.

Pricing of Inpatient Claims

Unless the contract states otherwise, all outpatient services, including observation and emergency room services, furnished to a customer by a hospital during an uninterrupted encounter (no discharge home) on the date of a customer's inpatient admission or immediately preceding the date of a customer's inpatient hospital admission, regardless of the number of uninterrupted days prior to the inpatient admission, will be paid under the applicable inpatient MS-DRG.

SNF Consolidated Billing (SNF CB)

Consolidated Billing Payment for the majority of services to beneficiaries in a Medicare-covered Part A SNF stay, including most services provided by entities other than the SNF, are included in a bundled prospective payment to the SNF. The SNF must bill these bundled services in a consolidated bill. For services subject to consolidated billing (CB) and provided by entities other than the SNF, the entity looks to the SNF for payment and must not bill separately for those services.

CB RESOURCES: For more information, take the SNF CB web-based training course on the Medicare Learning Network® (MLN) Learning Management and Product Ordering System. To help determine how CB applies to specific services, refer to the flow charts in the Skilled Nursing Facility Prospective Payment System educational product.

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Processing of Hospice Claims

When a Medicare Advantage (MA) customer elects hospice care, but chooses not to dis-enroll from the plan, the customer is entitled to continue to receive any MA benefits which are not the responsibility of the hospice through Cigna. Under such circumstances the premium Cigna receives from the Centers for Medicare and Medicaid Services (CMS) is adjusted to hospice status. As of the day the customer is certified as hospice, the financial responsibility for that customer shifts from Cigna to Original Medicare. During a hospice election, Original Medicare covers all Medicare-covered services rendered with cost-sharing of Original Medicare. Cigna will remain financially responsible for any benefits above Original Medicare benefits that are non-hospice related. Non-Medicare covered services, such as vision eyewear allowable, prescription drug claims, and medical visit transportation will remain the responsibility of Cigna. Plan cost-sharing will apply to Cigna covered services. If the customer chooses original Medicare for coverage of covered, non-hospice-care, Original Medicare services and also follows MA plan requirements, then, the customer pays plan cost-sharing and Original Medicare pays the provider. Cigna will pay the provider the difference between Original Medicare cost-sharing and plan cost-sharing, if applicable. Plan rules must still be followed and apply for both professional and facility charges. An HMO customer who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost-sharing; A PPO customer who receives services out of network and followed plan rules is only responsible for cost-sharing amounts applicable to their PPO plan. The customer need not communicate to the plan in advance his/her choice of where services are obtained. When a customer revokes hospice care, financial responsibility for Medicare-covered services will return to the plan on the first of the month following the revocation.

The following are the submission guidelines for Medicare Advantage customers enrolled in Hospice:

Hospice-Related Services

Medicare hospices bill the Medicare fee-for-service contractor for customers who have coverage through Medicare Advantage just as they do for customers, or beneficiaries, with fee-for-service coverage. Billing begins with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X or 82X. If the customer later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42 should be submitted as soon as possible so the customer's medical care and payment is not disrupted.

Medicare physicians may also bill the Medicare fee-for-service contractor for customers who have coverage through Medicare Advantage as long as all current requirements for billing for hospice beneficiaries are met. These claims should be submitted with a GV or GW modifier as applicable. Medicare contractors process these claims in accordance with regular claims processing rules. When these modifiers are used, contractors are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked. MA plan customers that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service

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beneficiary until the first day of the month following the month in which hospice was revoked.

Non-Hospice Services

- For Part A services not related to the customer’s terminal condition, submit the claim to the fiscal intermediary using the condition code 07.
- For Part B services not related to the customer’s terminal condition, submit the claim to the Medicare carrier with a “GW” modifier.
- For services rendered for the treatment and management of the terminal illness by a non-hospice employed attending physician, submit the claim to the fiscal Intermediary/ Medicare carrier with a “GV” modifier.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320-Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for customers who have elected hospice coverage. The Medicare Managed Care Manual, Chapter 11, Sections 40.2 and 50, and the CMS Program Memorandum AB-03-049 also outline payment responsibility and billing requirements for hospice services. This documentation is also available online at the CMS website: www.cms.gov.

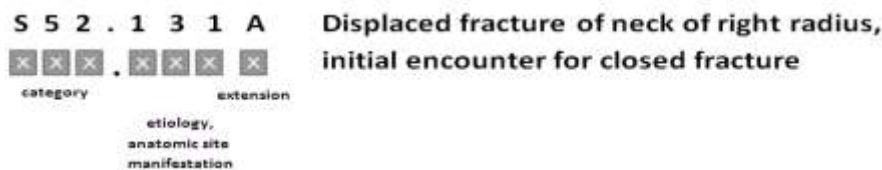
ICD-10 Diagnosis and Procedure Code Reporting

In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors, and other health care professionals, as well as vendors and trading partners. Providers must be diligent about confirming the accuracy of their diagnoses and ensure that their diagnosis and coding practices comply with all applicable legal requirements

The U.S. Department of Health and Human Services released a rule on July 31, 2014 finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearing houses to transition to ICD-10, the tenth revision of the International Classification of Diseases.

ICD-10 (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

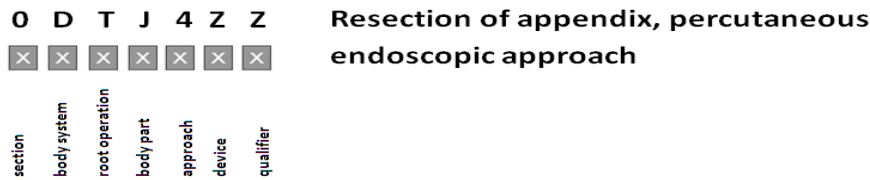
- **ICD-10-CM** for Diagnosis coding is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 characters instead of the 3 to 5 characters used with ICD-9-CM, adding more specificity.



- **ICD-10-PCS** for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD- 10-PCS uses 7 alphanumeric characters instead of the 3 or 4 numeric

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characters used under ICD-9-CM procedure coding. Coding under ICD- 10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.



Note: Procedure codes are only applicable to inpatient claims and not prior authorizations.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT or HCPCS coding for outpatient procedures.

Billable vs. Non-Billable Codes

- A billable ICD-10 code is defined as a code that has been coded to its highest level of specificity.
- A non-billable or ICD-10 code is defined as a code that has not been coded to its highest level of specificity. If a claim is submitted with a non-billable code, the claim will be rejected.
- The following is an example of a billable ICD-10 code with corresponding non-billable codes.

BILLABLE ICD-10 CODES	NON-BILLABLE ICD-10 CODES
M1A.3110 - Chronic gout due to renal impairment, right shoulder, without tophus	M1A.3 - Chronic gout due to renal impairment
	M1A.311 - Chronic gout due to renal impairment, right shoulder

*It is acceptable to submit a claim using an unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.

Questions Concerning ICD-10 and Claim Submission Guidelines

If you believe any codes were previously submitted in error (for example, the patient never had the condition listed), contact your Provider Education Specialist or direct your comment to CCQI@cigna.com and provide the patient name and diagnosis code so the code can be researched and retracted, if appropriate.

Visit <https://medicareproviders.cigna.com/icd-10> , for further Provider Resource tools.

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Coordination of Benefits

Medicare Secondary Payer (MSP) and Subrogation Guidelines

General Terms & Definitions

Term	Definition
Allowable Expense	Any expense customary or necessary, for health care services provided as well as covered by the customer's health care plan.
Conclusion	COB is applying the NAIC rules to determine which plan is primarily responsible and secondarily responsible when alternate coverage exists. If COB is to accomplish its purpose, all plans must adhere to the structure set forth in the Model COB regulations. Medicare Secondary Payer (MSP) provisions apply for Medicare beneficiaries under certain conditions.
Coordination of Benefits (COB)	Benefits that a person is entitled to under multiple plan coverages. Coordination of Benefits (COB) is the process of determining and reconciling individual payor liability for reimbursement when a customer is eligible for benefits coverage under more than one insurance company or other payor type (e.g., Medicare / Medicaid). Terms and conditions within the Summary of Benefits for each plan will generally dictate which payor is primary or secondary and any mathematical formula associated for calculating each payor's portion of coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding one hundred percent of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners (NAIC) COB Model Regulations Guidelines.
Order of benefit determination rule	Rules which, when applied to a particular customer covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in providing benefits for that customer. A plan will be determine to have Primary or Secondary responsibility for a person's coverage with respect to other plans by applying the NAIC rules.
Medicare Secondary Payer (MSP)	Medicare Secondary Payer refers to situations where another entity or insurance company is required to pay for covered services before Medicare.
Primary	This carrier is responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists.
Secondary	This carrier is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment not to exceed the total amount billed (maintenance of benefits).

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Common Situations of Primary vs. Secondary Payer Responsibility

The following list identifies some common situations when Medicare and other health insurance or coverage may be present, and which entity will be the primary or secondary payer.

If the customer/beneficiary:	The below condition exists:	The below program pays first:	The below program pays secondary:
Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family customer's current employment	The employer has more than 20 employees, or at least one employer is a multi-employer group that employs 20 or more employees	The Group Health Plan (GHP) pays primary	Cigna/Medicare pays secondary
Is age 65 or older and is covered a Group Health Plan (GHP) through current employment or a family customer's current employment	The employer has less than 20 employees	Cigna/ Medicare pays primary	Group Health Plan (GHP) pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family customer's current employment	The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees	The Large Group Health Plan (LGHP) pays primary	Cigna/ Medicare pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family customer's current employment	The employer employs less than 100 employees	Cigna/ Medicare pays primary	Large Group Health Plan (LGHP) pays secondary
Is age 65 or older or entitled based on disability and has	Does not matter the number of employees	Cigna/ Medicare pays primary	Retirement Insurance pays secondary

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retirement insurance only			
Is age 65 or older or is entitled based on disability and has COBRA coverage	Does not matter the number of employees	Cigna/ Medicare pays primary	COBRA pays secondary
Becomes dually entitled based on age/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block one above	The Group Health Plan (GHP) pays primary for the first 30 months	Cigna/ Medicare pays secondary (after 30 months Cigna pays primary)
Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance	Had insurance prior to becoming dually entitled with ESRD as in block one above and then retired	The Retirement Insurance pays primary for the first 30 months	Cigna /Medicare pays secondary (after 30 months Cigna pays primary)
Becomes dually entitled based on age/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block one above and picks up COBRA coverage	COBRA insurance would pay primary for the first 30 months (or until the customer drops the COBRA coverage)	Cigna/ Medicare pays secondary (after 30 months Cigna pays primary)
Becomes dually entitled based on disability/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block three above	The Large Group Health Plan (LGHP) pays primary	Cigna/ Medicare pays secondary (after 30 months Cigna pays primary)
Becomes dually entitled based on disability/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block three above and picks up the COBRA coverage	COBRA insurance would pay primary for the first 30 months or until the customer drops the COBRA coverage	Cigna/ Medicare pays secondary (after 30 months Cigna pays primary)

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Basic Processing Guidelines for COB

For Cigna to be responsible as either the primary or secondary carrier, the customer must follow all HMO/PPO rules (i.e. pay copays and follow appropriate referral process as applicable).

When Cigna is the secondary insurance carrier:

- All Cigna guidelines must be met in order to reimburse the provider (i.e. pre-certification, referral forms, etc.).
- The provider collects only the copayments required.
- Be sure to have the customer sign the “assignment of benefits” sections of the claim form. Once payment and/or EOB are received from the other carriers, submit another copy of the claim with the EOB of Cigna for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When Cigna is the primary insurance carrier:

- The provider collects the copayment required under the customer’s Cigna plan.
- Submit the claim to Cigna first
- Be sure to have the customer sign the “assignment of benefits” sections of the claim form.
- Once payment and/or Remittance Advise (RA) has been received from Cigna, submit a copy of the claim with the RA to the secondary carrier for adjudication.
 - Please note: Cigna is a total replacement for Medicare.
- Medicare cannot be secondary when customers have Cigna.
- Medicaid will not pay the copay for Cigna customers.

Worker's Compensation

Cigna does not cover worker’s compensation claims. When a provider identifies medical treatment as related to an on-the-job illness or injury, Cigna must be notified. The provider will bill the worker’s compensation carrier for all services rendered, not Cigna.

Subrogation

Subrogation is the substitution of one party in place of another with respect to a legal claim. In the case of a health plan which has paid benefits for its insured, the health plan is substituted in place of its insured and can make legal claims against the party which should be responsible for paying those bills such as the person who caused the insured’s injuries and their third party insurer (i.e. property and casualty insurer, automobile insurer, or worker’s compensation carrier).

COB protocol, as mentioned above, would still apply in the filing of the claim.

Patients who may be covered by third party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to Cigna with any information regarding the third party carrier (i.e. auto

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insurance name, lawyers name, etc.). All claims will be processed per the usual claims procedures.

Cigna uses a contracted vendor for review and investigation of all possible subrogation cases. This vendor coordinates all requests for information from the customer, provider and attorney name(s)/office(s) and assists with settlements. For questions related to a subrogated case, please contact Customer Service at **1-855-744-0223**. An experienced subrogation representative from our vendor, The Rawlings Group, will gladly provide assistance.

Dual Eligible

Dual Eligible Individuals

Many customers may have Cigna as their primary insurance payer and Medicaid as their secondary payer. You must coordinate the benefits of these “dual eligible” Cigna customers by determining whether the customer should be billed for the deductibles, copayments, or coinsurances associated with their benefit plan. Providers may not assess a QMB (Qualified Medicare Beneficiary) or QMB-Plus individual for Cigna copayments, coinsurances, and/or deductibles.

Providers can accept Cigna's payment as payment in full or seek additional payment from the appropriate state source. Additional information concerning Medicaid provider participation is available at: <https://careplantx.cigna.com/>

Providers are prohibited from billing, charging, collecting a deposit, seeking compensation or remuneration from, or having any recourse against any Cigna customer for fees that are the responsibility of Cigna.

Medicaid eligibility can be obtained by using the Medicaid Eligibility Verification System. If you do not have access to the system, please contact your State Medicaid agency for additional information.

Please note: Each state varies in their decision to cover the cost-share for populations beyond QMB and QMB-Plus.

Medicaid Coverage Groups

Qualified Medicare Beneficiary (QMB Only)

A “QMB” is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed three times the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and copayments (except for Part D). QMBs who do not qualify for any additional Medicaid benefits are called “QMB Only”. Providers may not assess a QMB for Cigna deductibles, copayments, or coinsurances.

Qualified Medicare Beneficiary Plus (QMB+)

A “QMB+” is an individual who meets standards for QMB eligibility and also meets criteria for full Medicaid benefits in the state. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or through spending down excess income to the Medically Needy level.

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Specified Low-Income Medicare Beneficiary (SLMB Only)

An “SLMB” is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than 120% FPL, and whose resources do not exceed three times the SSI limit. The only Medicaid benefit for which a SLMB is eligible is payment of Medicare Part B premiums. SLMBs who do not qualify for any additional Medicaid benefits are called “SLMB Only.”

Specified Low-Income Medicare Beneficiary Plus (SLMB+)

A “SLMB+” is an individual who meets the standards for SLMB eligibility, but who also meets the criteria for full state Medicaid benefits. Such individuals are entitled to payment of the Medicare Part B premium, as well as full state Medicaid benefits. These individuals often qualify for Medicaid by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.

Qualifying Individual (QI)

A “QI” is an individual who is entitled to Medicare Part A, has income that is at least 120% FPL but less than 135% FPL, resources that do not exceed three times the SSI limit, and who is not otherwise eligible for Medicaid. A QI is similar to an SLMB in that the only benefit available is Medicaid payment of the Medicare Part B premium; however, expenditures for QIs are 100% federally funded and the total expenditures are limited by statute. QIs are not otherwise eligible for full Medicare coverage.

Other Full Benefit Dual Eligibles (FBDE)

An “FBDE” is an individual who is eligible for Medicaid either categorically or through optional coverage groups such as Medically Needy or special income levels for institutionalized or home and community-based waivers, but who does not meet the income or resource criteria for QMB or SLMB.

Qualified Disabled and Working Individual (QDWI)

A “QDWI” is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in and purchase Medicare Part A. The individual’s income may not exceed 200% FPL and resources may not exceed twice the SSI limit. QDWIs are eligible only for Medicare.

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Appeals

Provider Appeals

An **appeal** is a request for Cigna to review a previously made decision related to medical necessity, clinical guidelines, or prior authorization and referral requirements. Cigna offers participating providers one level of appeal. The following should be considered when requesting an appeal:

- You must receive a notice of denial, or remittance advice before you can submit an appeal. Do not submit your initial claim in the form of an appeal.
- An appeal must be submitted within **60 days** of the original decision unless otherwise stated in your provider agreement.
- **With your appeal request, you must include:** an explanation of what you are appealing along with the rationale for appealing, a copy of your denial, any medical records that would support the medical necessity for the service, hospital stay, or office visit, and a copy of the insurance verification completed on the date of service. If necessary medical records are not submitted, the request will be returned without action until the medical records are submitted and must be received within the timeframe for which the provider must submit their request for appeal.
- Appeals can take up to **60 days** for review and determination.
- Timely filing requirements are not affected or changed by the appeal process or by the appeal outcome.
- If an appeal decision results in approval of payment contingent upon the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in the Cigna agreement.
- You may appeal a previous decision not to pay for a service. For example, claims denied for no authorization or no referral, including a decision to pay for a different level of care; this includes both complete and partial denials.
 - Examples of partial denials include: denials of certain levels of care, isolated claim line items not related to claims reconsideration issues, or a decreased quantity of office or therapy visits not related to claims reconsideration issues.
 - Total and partial denials of payment may be appealed using the same appeal process. Your appeal will receive an independent review by a Cigna representative not involved with the initial decision.
- Requesting an appeal does not guarantee that your request will be approved or that the initial decision will be overturned. The appeal determination may fully or partially uphold the original decision.
- You may appeal a health services or Utilization Management denial of a service **not yet provided**, on behalf of a customer. The customer must be aware that you are appealing on his or her behalf.

Submit an Appeal

1. To request an appeal, complete the [Medicare Advantage Appeals and Claims Disputes](#) form.

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2. Attach Medical Records
3. Submit your appeal in one of the following ways:
 - a. via secure e-mail to: FAX-SOL@healthspring.com
 - b. For large medical record files, you may mail or fax the appeal request form attached to a CD containing medical records to

Appeal Type	PO Box	Fax Number
Medical Appeals Standard	PO Box 188081 Chattanooga, TN 37422	855-350-8671
Medical Appeals Expedited	PO Box 188082 Chattanooga, TN 37422	855-350-8672
Part C IRE	PO Box 188083 Chattanooga, TN 37422	855-594-4423
Fast Track (QIO) Appeals	PO Box 188084 Chattanooga, TN 37422	855-594-4432
Contracted Provider Appeals (Post-Service)	PO Box 188085 Chattanooga, TN 37422	855-699-8985

Customer Appeals

Customer Appeals are processed according to Medicare guidelines. Please visit <https://www.cigna.com/medicare/resources/appeals-exceptions>

Claim Disputes/Reconsiderations

You have up to 180 days from claim payment date to request a reconsideration. You may request claim reconsideration if you feel your claim was not processed appropriately according to the Cigna claim payment policy or in accordance with your provider agreement. A claim dispute/reconsideration request is appropriate for disputing denials such as coordination of benefits, timely filing, or missing information. Payment retractions, underpayments/overpayments, as well as coding disputes should also be addressed through the claim dispute/reconsideration process. Cigna will review your request, as well as your provider record, to determine whether your claim was paid correctly.

Provider Information, Roles and Responsibilities Access and Availability Standards for Providers

- A Primary Care Physician (PCP) must have their primary office open to receive Cigna customers at least 20 hours per week.
- The PCP must ensure that coverage is available 24 hours a day, seven days a week.
- PCP offices must be able to schedule appointments for Cigna customers at least two (2) months in advance of the appointment.
- A PCP must arrange for coverage during absences with another Cigna Participating Provider as agreed upon in the Provider Agreement.

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PRIMARY CARE ACCESS STANDARDS	
Appointment Type	Access Standard
Urgent/Emergent	Immediately
Non-urgent/non-emergent	Within one (1) week
Routine and preventive	Within thirty (30) business days
On-call response (after hours)	Not to exceed an hour in the event of an emergency
Waiting time in office	Thirty (30) minutes or less

SPECIALIST ACCESS STANDARDS	
Appointment Type	Access Standard
Urgent/Emergent	Immediately
Non-urgent/non-emergent	Within one (1) week
Elective	Within thirty (30) business days
High index of suspicion of malignancy	Less than seven (7) days
Waiting time in office	Thirty (30) minutes or less

BEHAVIORAL HEALTH ACCESS STANDARDS	
Appointment Type	Access Standard
Emergency and non-life threatening	Within six (6) hours
Urgent/symptomatic	Within forty-eight (48) hours
Routine	Within ten (10) business days

After-hours Access Standards

All Participating Providers must return telephone calls related to medical issues. Emergency calls must be returned within 60 minutes of the receipt of the telephone call. Non-emergency calls should be returned within a 24-hour time period. A reliable 24 hours a day/7 days a week answering service with a beeper or paging system and on-call coverage arranged with another participating provider of the same specialty is preferred. Provider answering machines should direct customers to the nearest emergency room in the case a provider, office staff or live party is not available to assist the customer after hours.

Cigna conducts a yearly survey to monitor provider's access and availability compliance. The survey is conducted through a telephonic outreach to provider offices by a contracted vendor. Surveyors will require office staff to answer questions in regards to appointment availability, physician accessibility and after hours care. In addition, calls are made after hours to ensure all answering services and answering machines have the appropriate messaging or after hours physician information for customers.

Please ensure your office staff are available and trained to not only answer access and availability questions but to assist customers with their routine, urgent and emergent care

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needs. Cigna will notify you in writing if your office fails to meet any of the access and availability standards as part of the survey. A Cigna representative will contact your office directly if a grievance is received in regards to access and availability for your office.

Primary Care and Specialist Responsibilities

Providers Designated as Primary Care Physicians (PCPs)

Cigna recognizes Family Medicine, General Practice, Geriatric Medicine and Internal Medicine physicians as PCPs.

Cigna may recognize Infectious Disease Physicians as PCPs for customers who may require a specialized physician to manage their specific health care needs.

All contracted, credentialed providers participating with Cigna are listed in the region-appropriate Provider Directory, which is provided to customers and made available to the public via the online provider directory via medicareproviders.cigna.com

Role of the PCP

Cigna **HMO** customers must select a Cigna participating PCP at the time of enrollment. PCP selection is not required for **PPO** customers, but is recommended. The PCP is responsible for managing all the health care needs of a Cigna customer as follows:

- Manage the health care needs of Cigna customers who have chosen the physician as their PCP.
- Ensure that each customer receives treatment as frequently as is necessary based on the customer's condition.
- Develop an individual treatment plan for each customer.
- Submit accurate and timely claims and encounter information for clinical care coordination.
- Comply with Cigna's pre-authorization and referral procedures, as applicable.
- Refer customers to appropriate Cigna Participating Providers.
- Comply with Cigna's Quality Management and Utilization Management programs.
- Participate in Cigna's 360/Enhanced Encounter Comprehensive Assessment Program. For more information about this program, connect with your Network Operations Representative.
- Use appropriate designated ancillary services.
- Comply with emergency care procedures.
- Comply with Cigna access and availability standards as outlined in this manual, including after-hours care.
- Bill Cigna on the current CMS 1500 claim form or electronically in accordance with Cigna billing procedures.
- Ensure that, when billing for services provided, coding is specific enough to accurately capture the acuity and complexity of a customer's condition and ensure

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that the codes submitted are supported by proper documentation in the medical record.

- Comply with Preventive Screening and Clinical Guidelines.
- Adhere to Cigna's medical record standards as outlined in this manual.

The Role of the Specialist Physician

Each Cigna customer is entitled to see a Specialist Physician for certain services required for treatment of a given health condition. The Specialist Physician is responsible for managing all the health care needs of a Cigna customer as follows:

- Provide specialty health care services to customers as needed.
- Collaborate with the customer's Cigna Primary Care Physician to enhance continuity of health care and appropriate treatment.
- Provide consultative and follow-up reports to the referring physician in a timely manner.
- Comply with [access and availability standards as outlined in this manual](#) including after-hours care.
- Comply with Cigna's pre-authorization and referral process, as applicable
- Comply with Cigna's Quality Management and Utilization Management programs.
- Bill Cigna on the CMS 1500 claim form in accordance with Cigna's billing procedures.
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a customer's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Refer customers to appropriate Cigna Participating Providers.
- Submit encounter information to Cigna accurately and timely.
- Adhere to Cigna's [medical record standards as outlined in this manual](#).

Administrative, Medical and Reimbursement Policy Changes

From time to time, Cigna may amend, alter or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards and modification of Covered Services. Specific Cigna policies and procedures may be obtained by calling our Provider Services Department at 1-800-230-6138.

Cigna will communicate changes to the Provider Manual through the use of a variety of methods including but not limited to:

- Annual Provider Manual updates
- Letter
- Facsimile
- Email

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- Provider newsletters
- Website updates

Providers are responsible for the review and inclusion of policy updates in the provider manual, periodically checking Cigna's website for updates, and complying with these changes upon receipt of these notices or otherwise becoming aware or informed of such changes.

Communication among Providers

- The PCP should provide the Specialist Physician with relevant clinical information regarding the customer's care.
- The Specialist Physician must provide the PCP with information about his/her visit with the customer in a timely manner.
- The PCP must document in the customer's medical record his/her review of any reports, labs, or diagnostic tests received from a Specialist Physician.

Customer Assignment to New PCP (HMO Only)

Cigna Primary Care Physicians have a limited right to request a customer be assigned to a new Primary Care Physician. Such requests cannot be based solely on the filing of a grievance, appeal or the request for a secondary review or other action by the customer. A provider may request to have a customer moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- The customer is disruptive, unruly, threatening, or uncooperative to the extent that customer seriously impairs Cigna's or the provider's ability to provide services to the customer or to obtain new customers and the aforementioned behavior is not caused by a physical or Behavioral Health condition.
- Threats of physical harm to a provider and/or office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- The customer steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the managed care organization to coordinate treatment of the underlying medical condition).
- Other behavior, which results in serious disruption of the customer/physician relationship.

The provider should make reasonable efforts to address the customer's behavior, which has an adverse impact on the customer/physician relationship, through education and counseling, and if medically indicated, coordination with appropriate Specialists.

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If the customer's behavior cannot be remedied through reasonable efforts, and the PCP feels the relationship has been irreparably harmed, the PCP must complete the customer transfer request form (located by visiting www.medicareproviders.cigna.com) and submit it to Cigna.

Cigna will research the concern and document all actions taken by the provider and Cigna to cure the situation. This may include customer education, counseling or re-assignment. A Cigna PCP cannot request a disenrollment based on adverse change in a customer's health status or utilization of services medically necessary for treatment of a customer's condition.

Procedure

1. Once the physician has determined that the physician/customer relationship has been irreparably harmed, the physician should submit the completed Physician Notice to Discharge a Customer from Panel form to their Network Operations Representative and provide details and documentation to support their decision.
2. The physician is required to send the customer a notice informing them of their decision to terminate the physician/customer relationship. The notice must be sent to the customer at least 30 calendar days in advance of discharging a customer from a practice.
3. The physician is required to continue customer care for at least 30-45 days or longer to allow the customer time to select and be assigned a new PCP.
4. The physician will transfer, at no cost, a copy of the medical records of the customer to the new PCP and will cooperate with the customer's new PCP in regard to transitioning care and providing information regarding the customer's care needs.
5. A customer may also request a change in PCP for any reason. The PCP change that is requested by the customer will be effective the first (1st) of the month following the receipt of the request, unless circumstances require an immediate change.

Delegation

- **Delegation** is a formal process by which Cigna enters into a written contract with an entity to provide administrative or health care services for customers on Cigna's behalf.
- A function may be fully or partially delegated.
 - Full delegation allows all activities of a function to be delegated.
 - Partial delegation allows some of the activities to be delegated.
- The decision of what function may be considered for delegation is determined by the type of participation agreement a provider group has with Cigna, as well as the ability of the provider group to perform the function.
- Contact the local Cigna provider representative for detailed information on delegation.
- Although Cigna can delegate the authority to perform a function, it cannot delegate the responsibility.
- Delegated providers must comply with the responsibilities outlined in their Delegated

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Services Agreement and Cigna policies and procedures.

Non-Discrimination and Cultural Competency

Participating providers shall provide health care services to all customers, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

Participating providers shall provide covered services in a culturally competent manner to all customers by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled.

Examples of how a provider can meet these requirements include but are not limited to: translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

Cigna offers interpreter services and other accommodations for the hearing-impaired. Translator services are made available for non-English speaking or Limited English Proficient (LEP) customers. Providers can call Cigna customer service at **1-800-230-6138** to assist with translator and TTY services if these services are not available in their office location.

Physician Rights and Responsibilities

In addition to the rights and responsibilities outlined in your agreement with Cigna, Physicians have the following rights and responsibilities:

- Cigna encourages your feedback and suggestions on how service may be improved within the organization.
- If an acceptable customer-physician relationship cannot be established with a Cigna customer who has selected you as his/her Primary Care Physician, you may request that Cigna have that customer removed from your care.
- You may request claims reconsideration on any claims submissions in which you feel are not paid according to payment policy.
- You may request an Appeal on any claims submission in which you feel are not paid in keeping with the level of care rendered or Clinical Practice Guidelines.
- You may request to discuss any referral / authorization request with the Medical Director or Chief Medical Officer at various times in the review process.

Physician Responsibilities

- You must treat Cigna customers the same as all other customers in your practice, regardless of the type or amount of reimbursement.
- Primary Care Physicians shall use best efforts to provide customer care to new customers within four (4) months of enrollment with Cigna.
- Primary Care Physicians shall use best efforts to provide follow-up customer care to

customers that have been in the hospital setting within ten (10) days of hospital discharge.

- Primary Care Physicians are responsible for the coordination of routine preventive care along with any ancillary services that need to be rendered with authorization. (HMO)
- All providers are required to code to the highest level of specificity necessary to accurately and fully describe a customer's acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.
- Specialists must also provide continuous 24 hour, 7 days a week access to care for Cigna customers. (HMO)
- For HMO products, specialists must coordinate the referral process (i.e. obtain authorizations) for further care that they recommend. This responsibility does not revert back to the Primary Care Physician while the care of the customer is under the direction of the Specialist.
- In the event you are temporarily unavailable or unable to provide customer care or referral services to a Cigna customer, you must arrange for another physician to provide such services on your behalf. This coverage cannot be provided by an Emergency Room.
- You must provide continuity of care upon termination in accordance with your contract.
- For HMO products, you must utilize Cigna's participating physicians/facilities when services are available and can meet your customer's needs. Approval prior to referring outside of the contracted network of providers may be required.
- You must participate in Cigna's peer review activities as they relate to the Quality Management/ Utilization Review program.
- You must cooperate with Cigna's Quality Improvement (QI) activities to improve the quality of care and services and the customers' experience.
- You must allow Cigna to use your performance data; including the collection, evaluation and use of data in the participation of QI programs.
- You must maintain customer information and records in a confidential and secure manner.
- As a practitioner or provider of care you affirm to freely and openly discuss with customers all available treatment options regardless of whether the services may be covered services under the customer's benefit plan. This includes all treatment options available to them, including medication treatment options, regardless of benefit limitations.
- You may not balance bill a customer for providing services that are covered by Cigna. This excludes the collection of standard copays. You may bill a customer for a procedure that is not a covered benefit if you have followed the appropriate procedures outlined in the Claims section of this manual.
- All claims must be received within the timeframe specified in your contract.

Organizational Site Surveys

As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, freestanding surgical centers, home health agencies and inpatient, residential or ambulatory Behavioral Health or substance use disorder centers that do not hold an acceptable accreditation status or cannot provide evidence of successful completion of a recent State or CMS site survey. Any organizational provider may also be subject to a site survey as warranted subsequent to the receipt of a complaint.

Provider Participation

Providers must be contracted with and credentialed by Cigna according to the following guidelines:

PROVIDER: NEW TO PLAN AND NOT PREVIOUSLY CREDENTIALLED	
Status	Action
Practicing in a solo practice	Requires a signed contract and initial credentialing
Joining a participating group practice	Requires initial credentialing

PROVIDER: ALREADY PARTICIPATING AND CREDENTIALLED	
Status	Action
Leaving a group practice to begin a solo practice	Does not require credentialing; however a new contract is required and the previous group practice affiliation is terminated
Leaving a participating group practice to join another participating group practice	Does not require credentialing yet the group practice affiliation will be amended
Leaving a participating group practice to join a non-participating group practice	The provider's participation is terminated unless the non-participating group signs a contract with Bravo Health/Cigna. Credentialing is still valid until recredentialing due date

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Emergency or Disaster Situations

In the event of a Presidential emergency declaration, a Presidential major disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – Cigna is responsible for ensuring customers have access to providers, services and medications during disasters and emergencies to avoid significant disruption.

When the state of emergency proclamation or executive order is received, a notice is posted on the Cigna online provider website indicating the impacted state, counties, effective date and expiration date.

In order to ensure impacted customers have access to the services needed as of declaration effective date, Cigna:

- Waives referral requirements in full for Medicare covered benefits for customers in the affected counties.
- Temporarily reduces plan-approved out-of-network cost-sharing to in-network cost-sharing amounts;
- Waives the 30-day notification requirement to customers as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the customer;
- Allows Part A and Part B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A and Part B benefits must, per 42 CFR § 422.204(b)(3), be furnished at Medicare certified facilities).

Note that:

- A physician practicing in an affected county, but treating a MAPD customer who is visiting from an unaffected county/state and unable to leave the area will not require a referral or authorization.
- A physician practicing in an unaffected county/state, but treating an evacuated MAPD customer who resides in an affected county will not require a referral or authorization.

Cigna maintains the above in effect until the declaration is lifted or expires.

Provider Directory Update Requirements

CMS requires all Medicare Advantage Organizations (MAOs) to outreach to contracted providers on a quarterly basis in order to verify provider's demographic data published in the Cigna Provider Directories. CMS also requires MAOs to update Provider Directories within 30 days of receipt of new or revised demographic information.

Cigna utilizes the Council for Affordable Quality Healthcare (CAQH) to make quarterly outreaches to contracted practitioners. For all other provider types, Cigna reaches out via mail and provides instructions to complete the quarterly attestation process.

If you move locations, change phone numbers or any other demographic information, update the information within seven days of the change. Please do not wait for the quarterly update to make such a change. If you are a practitioner, visit the CAQH site to make the updates. If you are a facility/ancillary provider, submit your changes by visiting

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www.chsproviderdatavalidation.com/.

As a contracted provider, you are required to comply with the outreach request and supply updated information within the allotted timeframe. Failure to provide a response to the quarterly outreach will result in suppression from our Provider Directory.

Suppression from the Directory means that customers and other providers will not be able to view you as a Participating Provider in the Cigna networks. If you were removed from the Directory and you are a practitioner, visit the CAQH site to update/attest to your demographic information. If you are a facility/ancillary provider, submit your attestation by visiting www.chsproviderdatavalidation.com/.

The accuracy of our Directories directly impacts the customers we both serve. We take this compliance requirement very seriously and expect that you will cooperate fully with the attestation and validation process. If a provider fails to cooperate, we will take action, including suppression and potential termination from participation from our Medicare Advantage plans.

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Provider Communications and Marketing

Guidelines

The information below is a general guideline to assist Cigna providers who have contracted with multiple Medicare Advantage plans and accept Medicare FFS customers to determine what customer outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering, or attempting to steer an undecided potential enrollee toward a specific plan or limited number of plans, based on the financial interest of the provider or agent. Providers should remain neutral parties when assisting beneficiaries with enrollment decisions.

Providers can:

- Mail/call their customer panel to invite customers to general educational events run by Cigna to learn about the Medicare and/or Medicare Advantage program. This is not a sales/marketing meeting. No sales or plan materials can be distributed. Sales representative cards can be provided upon request.
- Have additional mailings (unlimited) to customers about participation status but must list all participating Medicare Advantage plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior CMS approval and the agreement of all plans listed.
- Notify customers in a letter of a decision to participate in Cigna sponsored programs.
- Utilize a provider/customer newsletter to communicate information to customers on a variety of subjects.
- Provide objective information to customers on specific plan formularies, based on a customer's medications and health care needs.
- Refer customers to other sources of information, such as the State Health Insurance Assistance Program (SHIP), Cigna marketing representatives, state Medicaid, or **1-800-Medicare** to assist the customer in learning about the plan and making a health care enrollment decision.
- Display and distribute Cigna MA and MAPD plan marketing materials in common areas of provider offices. The office must display or offer to display materials for all participating MA plans.
- Notify customers of a physician's decision to participate exclusively with Cigna for Medicare Advantage or to close panel to original Medicare FFS if appropriate.
- Display promotional and educational items with the Cigna logo; however, promotional items cannot be displayed in areas where care is being delivered.
- Allow Cigna to have a room/space in provider offices completely separate from where customers are receiving care, to provide beneficiaries' access to a Cigna sales representative.

Providers cannot:

- Urge or steer patients towards any specific plan or limited set of plans.
- Accept or collect Medicare scope of appointment or enrollment applications.

- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Conduct health screenings for potential enrollees as a marketing activity.
- Expect or accept compensation directly or indirectly from a plan for any marketing or enrollment activities.
- Call patients who are dis-enrolling from the health plan to encourage re-enrollment in a health plan.
- Mail marketing materials to patients on behalf of a health plan.
- Call patients to invite them to sales activities for a health plan.
- Advertise using Cigna's name without Cigna's prior consent.

The information contained in this section should not be construed as legal advice. Providers should consult the Medicare Communication and Marketing Guidelines published by CMS to learn more about CMS's requirements regarding provider outreach.

Behavioral Health Responsibilities of the Primary Care Physician

The PCP can participate in the identification and treatment of their customer's behavioral health needs. His/her responsibilities include:

- Screening and early identification of behavioral health and substance use disorders
- Treating customers with behavioral health care needs within the scope of his/her practice and according to established Clinical Practice Guidelines. These can be customers with co-morbid physical and minor behavioral health problems or those customers refusing to access a behavioral health or substance use disorder provider, but requiring treatment
- Consultation and/or referral of complex behavioral health customers or those not responding to treatment
- Communication with other physical and behavioral health providers on a regular basis

Access to Care

Patients may access behavioral health services as needed:

- Patients may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment
- Patients may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP's scope of practice. They may request a referral to a behavioral health practitioner. Referrals however, are not required to receive most in-network behavioral health or substance use disorder services
- Patients and providers can call Cigna Behavioral Health Customer Service to receive orientation on how to access behavioral health services, provider information, and Prior Authorizations at **1-866-780-8546**.

Medical Record Documentation

When requesting Prior Authorization for specific services or billing for services provided,

behavioral health providers must use the current DSM multi-axial classification system and document a complete diagnosis. The provision of behavioral health services requires progress note documentation that corresponds with day of treatment, the development of a treatment plan, outcome of treatment and the discharge plan as applicable for each customer in treatment.

Continuity of Care for Behavioral Health

Continuity of Care is essential to maintain customer stability. Behavioral health practitioners and PCPs, as applicable, are required to:

- Evaluate customer if he/she was hospitalized for a behavioral health condition within 7 days post-discharge.
- Provide customers receiving care with contact information for any emergency or urgent matter arising that necessitates communication between the customer and the provider.
- Evaluate customer needs when the customer is in acute distress.
- Communicate with the customer's other health care providers.
- Identify those customers necessitating follow-up and refer to Cigna's behavioral health focused case management program as necessary.
- Discuss cases as needed with a peer reviewer.
- Make request to Cigna for authorization for customer in an active course of treatment with a non-participating practitioner.

Utilization Management for Behavioral Health

Cigna's Health Services Department coordinates behavioral health care services to ensure appropriate utilization of behavioral health and substance use disorder treatment resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the customers.

Cigna's Utilization Management staff base their utilization-related decisions on the clinical needs of customers, the customer's Benefit Plan, well-established clinical decision-making support tools, the appropriateness of care, Medicare National Coverage Guidelines, health care objectives, scientifically-based clinical criteria and treatment guidelines in the context of provider and/or customer-supplied clinical information and other relevant information. For requests for behavioral health services that require authorization, Cigna will approve the request or issue a notice of denial if the request is not medically necessary.

Contract Exclusions for Behavioral Health

Cigna retains the right to deliver certain services through a vendor or contractor. Unless your contract specifically dictates otherwise, should Cigna elect to deliver certain services for which you are currently contracted to provide through a vendor or contractor, you will be provided a minimum of thirty (30) day's advance notice and your contract terms will be honored during that notice period. After such time and notification, Cigna retains the right to discontinue reimbursement for services provided by the vendor or contractor.

Pharmacy

Pharmacy Prescription Benefit

Part D Drug Formulary

Detailed information regarding Part D drugs, their utilization management requirements (prior authorization, step therapy, quantity limits), non-extended day supply limitations, any plan year negative changes, and most recent plan formularies is [available here](#).

Cigna utilizes a customized classification system defined by Express Scripts® National Pharmacy and Therapeutics (P&T) Committee to develop Part D drug formularies that include drug categories and classes covering a variety of disease states. Each category must include at least two drugs, unless only one drug is available for a particular category or class. Cigna includes all or substantially all drugs in protected classes, as defined by The Centers for Medicare and Medicaid Services (CMS). Express Scripts® National Pharmacy and Therapeutics (P&T) Committee reviews all formularies for clinical appropriateness, including the utilization management edits placed on formulary products. Cigna submits all formulary changes to CMS according to the timelines designated by CMS.

A Part D drug is a drug that meets the following criteria:

- May be dispensed only by prescription
- Approved by the FDA
- Used and sold in the US
- Used for a medically accepted indication
 - Medically accepted indication is defined as both the uses approved by the FDA and off-label uses supported by the CMS recognized compendia, Micromedex and American Hospital Formulary Service Drug Information (AHFS-DI). On their own, uses described by clinical guidelines or peer-reviewed literature are insufficient to establish a medically accepted indication.
 - National Comprehensive Cancer Network (NCCN), Clinical Pharmacology, and Lexicomp, as well as peer-reviewed literature are also used to determine medically accepted indications for drugs or biologicals used off-label in an anti-cancer chemotherapeutic regimen.
- Includes prescription drugs, biologic products, vaccines that are reasonable and necessary for the prevention of illness, insulin, and medical supplies associated with insulin that are not covered under Parts A or B (syringes, needles, alcohol, swabs, gauze, and insulin delivery systems not otherwise covered under Medicare Part B).

Drugs excluded under Part D include the following:

- Drugs for which payment as so prescribed or administered to an individual is available for that individual under Part A or Part B
- Drugs or classes of drugs, or their medical uses, which are excluded from coverage or otherwise restricted under Medicare (with the exception of smoking cessation products)
- Drugs for anorexia, weight loss or weight gain

- Drugs to promote fertility
- Drugs for cosmetic purposes and hair growth
- Drugs for symptomatic relief of coughs and colds
- Vitamins and minerals (except for prenatal vitamins and fluoride preparations)
- Non-prescription drugs
- Outpatient prescriptions for which manufacturers require the purchase of associated tests or monitoring services as a condition for getting the prescription (manufacturer tying arrangements)
- Agents used for treatment of sexual or erectile dysfunction (ED) (except when prescribed for other FDA-approved indications such as pulmonary hypertension)

Part D Utilization Management

Cigna formularies include utilization management requirements that include Prior Authorization, Step Therapy and Quantity Limits. The Part D utilization management is [available here](#).

Prior Authorization (PA)

For a select group of drugs, Cigna requires the customer or their physician to get approval for certain prescription drugs before the customer is able to have the prescription covered at their pharmacy. A PA requirement is placed on certain drugs to gather necessary information to determine if the drug should be covered under the customer's Medicare Part B or Part D benefit. Another common reason for a drug's PA requirement is to ensure that a drug is being used for a medically accepted or Part D allowed indication as defined above. Finally, some drugs may have more detailed PA criteria that also require submission of medical information, such as lab results, and current and/or past medication history.

Step Therapy (ST)

For a select group of drugs, Cigna requires the customer to first try and fail certain drugs/drug classes to treat their medical condition before covering another drug for that condition.

Quantity Limits (QL)

For a select group of drugs, Cigna limits the amount of the drug that will be covered without prior approval.

How to File a Coverage Determination

A coverage determination (CD) is any decision that is made by or on behalf of a Part D plan sponsor regarding payment or benefits to which a customer believes he or she is entitled. Coverage determinations may be received orally or in writing from the customer (or appointed representative) or the customer's prescribing physician.

Electronic prior authorization (ePA) is Cigna's preferred way to receive a coverage determination request. To create a free account, visit go.covermy meds.com/HealthSpringPA or bit.ly/expressscripts_faster_pa. Cigna also supports other methods of electronic prior authorization, such as SureScripts or ExpressPath.

For the provider call center, please call: **1-877-813-5595** or fax: **1-866-845-7267**

Mailing address:

Cigna Coverage Determination and Exceptions
8455 University Place #HQ2L-04
St. Louis, MO 63121

To ensure timely review of a CD and to ensure awareness of what Cigna requires for the most commonly requested drugs, drug-specific CD forms are [available here](#) or by requesting a faxed copy when calling **1-877-813-5595**.

For standard requests, the prescriber will receive the outcome of a coverage determination via phone, fax or a letter placed in USPS mail no later than seventy-two (72) hours after the initial request was received or receipt of the supporting statement. For urgent requests, the prescriber will receive the outcome notification via phone, fax or a letter placed in USPS mail no later than twenty-four (24) hours after the initial request was received or receipt of the supporting statement. If the request is regarding payment for a prescription drug the customer already received, an expedited request is not permitted and Cigna will provide a decision and written notice no later than fourteen (14) calendar days from the date the request was received.

The following information will be provided:

Decided Outcome of the Case	
Denied	<ol style="list-style-type: none">1. The specific reason for the denial taking into account the customer's medical condition, disabilities and special language requirements, if any;2. Information regarding the right to appoint a representative to file an appeal on the customer's behalf; and3. A description of both the standard and expedited redetermination processes and timeframes including conditions for obtaining an expedited redetermination and the appeals process.
Approved	The duration of the approval

How to File a Part D Appeal

A Part D appeal, or redetermination, must be filed within 60 calendar days from the date printed/written on the coverage determination denial letter and can be received orally or in writing from a customer, customer's representative, customer's prescribing physician or other physician. For a standard Part D appeal, Cigna will provide a decision and written notice no later than seven (7) calendar days from the date the request was received. For an expedited/urgent Part D appeal, Cigna will provide a decision no later than seventy-two (72) hours after receiving the appeal. Requestors may request an expedited appeal in situations where applying the standard time frame could seriously jeopardize the customer's life, health or ability to regain maximum function. If the request is regarding payment for a prescription

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drug the customer already received, an expedited appeal is not permitted. Such requests must be received in writing. Cigna will provide a decision and written notice no later than fourteen (14) calendar days from the date the request was received.

Part D Appeals Contact Information:

Phone: **1-866-845-6962**

Fax: **1-866-593-4482**

Mailing Address:

Cigna Medicare Clinical Appeals

P.O. Box 66588

St. Louis, MO 63166-6588

Pharmacy Networks

Cigna provides access to more than 68,000 network pharmacies throughout the country. This extensive network gives our customers – your patients – convenient access to many pharmacies in their area to choose for their unique pharmacy needs. Options range from large chain pharmacies to locally owned, independent retail pharmacies. Long-term care, home infusion, mail order/home delivery pharmacy options are available, as well.

Preferred Pharmacy Network

There are also a large number of pharmacies in our preferred pharmacy network, which offer lower copays on most prescriptions. Our preferred network of pharmacies includes over 32,000 retail pharmacies across the United States. Large national and regional chains in the preferred pharmacy network include Walmart and depending on the plan, Walgreens or CVS, and many of the most commonly used grocery store pharmacies. There are also numerous local and independent pharmacies options in the preferred pharmacy network. A more detailed list of preferred pharmacies is [available here](#) along with the full listing of the provider directories (by region), which include network pharmacy providers. Preferred pharmacies are identified using a grey shaded box in the provider directories. Patients can choose to use a pharmacy in either the standard or preferred network according to their needs, but only preferred pharmacies can offer reduced cost sharing on prescription drugs. This can often result in significant total savings over the course of a year, especially for customers that take multiple prescription medications.

Pharmacy Quality Programs

Narcotic Case Management

The Narcotic Case Management Program is designed to identify patterns of inappropriate opioid utilization with the goal to enhance customer safety through improved medication use. Quarterly reports are generated using an algorithm that identifies customers who may be potentially at risk of opioid overutilization based on the number of prescribers, pharmacies, and calculated morphine milligram equivalent (MME) per day. Individuals who have active cancer-related pain, are receiving hospice or palliative care, or are a resident of a LTC facility are excluded from the program. The Cigna clinical staff review claims data of all identified customers who meet the established criteria and determine whether further investigation with prescribers is warranted. If intervention is deemed appropriate, clinical staff will send written notification by fax to the prescribers involved in the customer's care requesting information

pertaining to the medical necessity and safety of the current opioid regimen. Cigna will reach out to discuss the case with the customer's opioid prescriber(s) in an attempt to reach a consensus regarding the customer's opioid regimen. If clinical staff is able to engage with prescribers, then action will be taken based on an agreed upon plan. In the most severe cases, clinical staff may collaborate with the prescriber(s) to implement customer-specific limitations to assist with control of inappropriate utilization or overutilization of opioid medications. The limitations may apply to opioid and/or benzodiazepine medications and may require customers to use only selected pharmacies or prescribers for selected medications or limit the amount of opioid or benzodiazepine medication covered by the health plan. If Cigna does not receive a response from the prescribers, despite multiple outreach attempts, then limitations may be invoked based on the decision of an internal, multi-disciplinary team.

Medication Therapy Management

The Medication Therapy Management (MTM) program is designed to help improve medication therapy outcomes by identifying gaps in care, addressing medication adherence, and recognizing potential cost savings opportunities. The program is designed for customers that satisfy certain criteria provided by CMS. More information is [available here](#).

Eligible customers are automatically enrolled into the program and sent a welcome letter encouraging each customer to call to complete their Comprehensive Medication Review (CMR) before their annual wellness visit with their provider, so the customer can take their medication list to the appointment. A comprehensive medication review is a personal review of prescriptions, OTC medications, herbal therapies, and dietary supplements with a clinical pharmacist. After the completion of the CMR, any potential drug therapy problems (DTPs) that were identified are sent to the prescribing provider and/or primary care provider by mail or fax. Along with DTPs, the provider also receives an updated list of the customer's medication history through the previous 4 months. Also, an individualized letter, which includes a personal medication record of all medications discussed and a medication action plan, is mailed to the customer. If the customer has any questions or comments about the medication action plan, a phone number is provided for follow up.

In addition to the CMR, customers also receive targeted medication reviews (TMRs) quarterly. The TMRs are generated using the MTM software to review for specific drug therapy problems (DTPs). If any DTPs are identified, a letter may be mailed or faxed to the prescribing provider and/or primary care provider.

There is no additional cost for participation in the MTM program. MTM Program CMR completion rate is a Part D Star rating based off the percentage of customers who meet eligibility criteria for MTM program and who receive a CMR. Refer eligible customers to the MTM program at **1-800-625-9432** to complete their annual CMR.

Drug Utilization Review

Cigna performs reviews of prescription drug claims data to assess dispensing and utilization of medications for our customers. Drug Utilization Review (DUR) is a structured and systematic attempt to identify potential issues with drug therapy coordination among prescribers, unintentional adverse drug events (including drug interactions), and non-adherence with drug regimens among targeted classes of drugs. Retrospective Drug Utilization Review (rDUR) evaluates past prescription drug claims data, and concurrent Drug

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Utilization Review (cDUR) ensures that a review of the prescribed drug therapy is performed before prescription medications are dispensed. cDUR is typically performed at the point-of-sale, or point of distribution, by both the dispensing pharmacist and/or through automated checks that are integrated in the pharmacy claims processing system. Cigna tracks and trends all drug utilization data on a regular basis to enable our clinical staff to determine when intervention may be warranted, whether it is customer-specific or at a population level. Providers of targeted customers identified based on DUR activity will typically receive information regarding the quality initiative by mail or fax. rDUR initiatives that may be communicated to providers include:

- Failure to refill prescribed medications
- Drug-drug or drug-disease interactions
- Therapeutic duplication of certain drug classes
- Narcotic safety including potential abuse or misuse
- Use of medications classified as High Risk for use in the older population
- Use of multiple antidepressants, antipsychotics, or insomnia agents concurrently
- Multiple prescribers of the same class of psychotropic drug

Letters to providers will include the rationale for any of the particular concerns listed above that are the subject of the initiative. If you (as a provider) receive a letter indicating that you prescribed a medication that you did not prescribe, please notify Cigna using the contact information on the letter.

A multidisciplinary team determines the direction of pharmacy quality initiatives for the DUR program. The pharmacy quality initiative concepts originate from a variety of sources, including but not limited to, claims data analysis and trends, the Centers for Medicare and Medicaid Services (CMS), Pharmacy Quality Alliance (PQA) and National Committee for Quality Assurance (NCQA) quality measures and standards, Food and Drug Administration (FDA) drug safety notifications, clinical trials or clinical practice guidelines, and other relevant healthcare quality publications.

Opioid cDUR Drug Safety Edits

Opioid initiatives for 2021 continue to focus on strategies to help prevent and combat opioid overuse among our beneficiaries through the use of concurrent Drug Utilization Review (cDUR). Safety controls will be implemented at point-of-sale, including “soft” and “hard” cDUR edits, which will both reject the opioid claim. The dispensing pharmacy may override a “soft” rejection by entering the appropriate pharmacy professional service (PPS) codes upon consulting the prescriber and/or determining safe and appropriate use of the medication. “Hard” rejections may not be overridden at point-of-sale, and in order to request coverage of the medication(s), a coverage determination must be initiated. Listed below are the current opioid cDUR drug safety edits, which align with CMS guidance on required and recommended utilization management of opioid prescriptions:

- Opioid prescriptions are limited to a maximum of a 1-month supply OR a 7-day supply in opioid naïve customers. Cigna defines “opioid naïve” as customers who have not had an opioid medication filled within the past 108 days. This is a “hard” cDUR edit and will require a coverage determination for coverage under the beneficiary’s part D plan if a day supply exceeding these limits is needed.

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- Opioid prescriptions for customers who have claims exceeding a total of 90 morphine milligram equivalents (MME) per day AND have 2 or more opioid prescribers will receive a “soft” rejection at point-of-sale. A coordination of care between the prescriber and dispensing pharmacist is encouraged. Upon consulting the prescriber and receiving approval, the dispensing pharmacist may use pharmacy professional service (PPS) codes to override the “soft” rejection.
- Opioid prescriptions will “soft” reject at point-of-sale if an interaction with a benzodiazepine is detected. The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides customer counseling, and/or determines that it is safe to dispense the medication(s).
- Opioid prescriptions for long-acting opioid medications will “soft” reject at point-of-sale if a duplication of therapy is detected between 2 or more long-acting opioid medications. The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides customer counseling, and/or determines that it is safe to dispense the opioid medication(s).

Prescription Drug Monitoring Programs Low Income Subsidy Program Information

Overview

The Federal Medicare “Extra Help” program, also known as the Low Income Subsidy (LIS) program, provides extra help to assist with Medicare prescription drug costs for individuals who have limited income and resources. Although most beneficiaries who are eligible for Low Income Subsidy benefits will automatically qualify for this program, there are many others who may qualify by applying for this valuable benefit. As a result, many individuals may not even know they are eligible. The Extra Help program has many benefits for qualified individuals including:

- Low or no monthly Part D premiums
- Low or no initial Part D deductible
- Coverage in the Donut Hole or Coverage Gap
- Greatly reduced costs for prescription drugs that are covered by the Medicare Part D plan and/or
- 90-day supply of Medicare Part D covered drugs for the same cost as a 30-day supply (applies to most but not all beneficiaries who qualify for Extra Help)

Eligibility

To be eligible for the Extra Help program individuals must reside in one of the 50 states or the District of Columbia and meet certain income and resource limits. Resources include items like savings, stocks and money in checking/savings accounts, but will not include an individual’s home or car. Income limits, set by the federal government, are used to determine eligibility for the Extra Help program and are based on the Federal Poverty Level (FPL) published by Department for Health & Human Services (DHHS).

Applying For Extra Help

Individuals with limited income and resources may qualify for Extra Help to reduce their out-of-

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pocket costs. Applying for Extra Help is easy. Cigna customers can choose from the following options:

- Phone call to the Social Security Administration (SSA) at **1-800-772-1213** (TTY **1-800-325-0778**) to apply over the phone or to request a paper application
- Apply online at www.SocialSecurity.gov/extrahelp
- Phone call to Premium Assist provided by Human Arc **1-877-236-4471**
 - Available for all Cigna customers who have been active for at least 60 days
 - Assists with screening for LIS eligibility and application submission
 - No charge for customers

If an individual does not qualify for the Extra Help Program, state programs may be available to help pay for prescription drug cost. Cigna encourages all customers to inquire about these Federal and State Programs.

Home Delivery Pharmacy

One of the most important ways to improve the health of your customers is to make sure they receive and take their medications as you prescribe.

Your patients can receive a three-month supply of their medications through mail order, making it easier for the customer as they only fill their script four times per year. Using preferred mail order will generally lower their costs, sometimes to as low as \$0, and improve their adherence. Talk to your patients about home delivery. We contract with approximately 68,000 network pharmacies throughout the country, including major retail pharmacy chains and independent pharmacies. A complete listing can be found on our website at the [Pharmacy Network Page](#).

Express Scripts®

The Express Scripts® Pharmacy, one of the leading home delivery companies, is the preferred home delivery pharmacy. Customers should first set up an account with Express Scripts® Pharmacy in order to get their current prescriptions filled through home delivery.

- Patients should call Express Scripts® at 1-877-860-0982 or register online at www.express-scripts.com
- Express Scripts® will reach out to the provider for the prescriptions

A complete listing of home delivery pharmacies can be found on our website at the [Pharmacy Network page](#).

Specialty Pharmacy

Accredo pharmacy, one of the leading specialty pharmacies, will be Cigna Medicare's preferred specialty pharmacy starting January 1, 2021. Accredo has a team of specialty-trained pharmacists and nurses who are available to help your patients with questions about their specialty medications, 24/7. Accredo is ready to work with you and your patient to help you receive the best possible care. To get started, simply contact an Accredo patient care advocate at (877) 826-7657.

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Medical Health Services

Overview

Cigna's Health Services Department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the customer.

Cigna Utilization Management staff base their utilization-related decisions on the clinical needs of customers, the customer's Benefit Plan, well-established clinical decision making support tools, the appropriateness of care, CMS Guidelines, health care objectives, and scientifically-based clinical criteria and treatment guidelines in the context of provider and/or customer-supplied clinical information and other such relevant information.

Cigna in no way rewards or incentivizes, either financially or otherwise, practitioners, Utilization Reviewers, clinical care managers, physician advisers or other individuals involved in conducting Utilization Review, for issuing denials of coverage or service, or inappropriately restricting care.

Goals

- To ensure that services are authorized at the appropriate level of care and are covered under the customer's health plan benefits.
- To monitor utilization practice patterns of Cigna's contracted physicians, hospitals, ancillary services, and specialty providers.
- To provide a system to identify high-risk customers and ensuring that appropriate care is accessed.
- To provide Utilization Management data for use in the process of re-credentialing providers.
- To educate customers, physicians, contracted hospitals, ancillary services, and specialty providers about Cigna's goals for providing quality, value-enhanced managed health care.
- To improve utilization of Cigna's resources by identifying patterns of over- and under-utilization that have opportunities for improvement.

Departmental Functions

- Prior Authorization
- Concurrent Review
- Discharge Planning
- Case Management and Disease Management
- Continuity of Care

Prior Authorization

Cigna requires authorization of certain services, medications, procedures, and/or equipment

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prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care. The authorization is typically obtained by the ordering provider, but may also be requested by the rendering provider. Participating providers are responsible for requesting Prior Authorization on behalf of the customer when required. Prior Authorization submission is recommended at least fourteen (14) business days in advance of the admission, procedure, or service when possible. Requests must include all pertinent clinical information to support the medical necessity of the services requested. The customer may also request a determination prior to delivery of services. In this event, Cigna will contact you for clinical information to support the request.

Please refer to the **2021 Authorization Requirements** located [here](#). If you are uncertain about the precertification requirement for a specific procedure, you may also outreach to our Provider Service Department from 7 a.m. - 6 p.m. CST at **1-800-230-6138**.

Precertification request forms can be found [here](#). Using the forms when faxing a Precertification Request provides the team with needed information to complete the request. Please include clinical information to support your request at time of submission.

Requirements will be routinely updated on a quarterly basis due to program or CPT/HCPCS coding changes. It is recommended that you check the authorization requirements via the website frequently and prior to delivering planned services. Prior Authorization is a determination of medical necessity and is not a guarantee of claims payment. Claim reimbursement may be impacted by various factors including eligibility, participating status, and benefits at the time the service is rendered.

The presence or absence of a service or procedure on the list does not determine coverage or benefits.

Log in to HSConnect or contact Provider Service Department to verify benefits, coverage, and customer eligibility. Authorization requests may be submitted by, phone, fax, Cigna’s portal, HSConnect, or mail 24 hours per day, 7 days per week. After confirming a customer’s eligibility and the availability of benefits, providers should submit all supporting documentation with the organization determination request via our Provider Portal, Fax or phone. Contact information for Fax and phone are:

STATE	PHONE	FAX
Behavioral Health (All Markets)	1-866-780-8546	866-949-4846
Drugs/Biologics Part B	1-888-454-0013	877-730-3858
Home Health Care	800-962-3016	800-872-8685
Care Allies	884-359-7301	866-233-6235
Precertification	800.453.4464	866-287-5834

Phone lines are staffed Monday through Friday between the hours of 8:00 a.m. and 6:00 p.m. EST.

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The Prior Authorization Department, under the direction of licensed nurses, clinical pharmacists, and medical directors, documents and evaluates requests for authorization, including:

- Confirmation that the customer is eligible for services with Cigna at the initial start of care
- Verification that the requested service is a covered benefit under the customer's benefit package
- Determination of the appropriateness of the services (medical necessity)
- Validation that the service is being provided by the appropriate provider and in the appropriate setting

The Prior Authorization Department documents and evaluates requests using CMS guidelines and nationally recognized criteria to make a determination of coverage. The provider may be notified electronically, orally, or in writing within the regulated CMS timeframes.

Examples of information required for a determination include, but are not limited to:

- Customer name and identification number
- Location of service (e.g., hospital or ambulatory care setting)
- Primary Care Physician name along with Tax Identification Number (TIN) or Provider Identification Number (PIN)
- Servicing/attending physician name including National Provider Identifier (NPI)
- Date of service
- Diagnosis
- Service/procedure/surgery description and CPT or HCPCS code
- Clinical information supporting the need for the service to be rendered

In order to provide optimal service to our providers and customers, submission of clinical information at the time of the request is essential. Cigna may outreach to you for necessary information in order to make a determination. Requests received without supporting documentation may experience delays in processing up to the regulatory timeframes as CMS rules require that appropriate information be requested before decisions are rendered. See below for details regarding decision and notification timeframes.

For customers who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a customer appears at an emergency room for care which is non-emergent, the PCP should be contacted for direction. The customer may be financially responsible for payment if the care rendered is non-emergent. Cigna also utilizes urgent care facilities to treat conditions that are non-emergent but require immediate treatment. Notification of Emergency Admissions must also be authorized by Cigna. Please be prepared to discuss the customer's condition and treatment plan with our Nurse Case Manager.

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Prior Authorization Department

The Prior Authorization department consists of nonclinical and clinical support staff trained to receive requests via portal, fax, telephone and mail. Pertinent information will be requested in order to efficiently and accurately process the medical necessity determination. Upon submission of the request, please be prepared with all necessary information noted above inclusive of accurate diagnosis, CPT/HCPCS coding, and rendering provider information.

As necessary, service requests will be forwarded to clinically licensed staff to complete a review to ensure benefit coverage, medical necessity, appropriateness of provider and place of service. Requests that cannot be approved utilizing CMS and nationally recognized, evidence-based criteria will be forwarded to a Pharmacist or Medical Director for review.

Approval notification may be delivered electronically, orally, or in writing.

Denials for medical necessity are issued only by appropriately licensed personnel such as a Medical Director or Pharmacist depending on the type of service request.

He/she may also make a decision based on administrative guidelines. The Medical Director or Pharmacist, in making the decision, may suggest alternative covered services to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, Cigna notifies the facility or providers office of the denial. Such notice is issued to the customer and the provider when appropriate, documenting the original request that was denied, the rationale for the decision, the alternative approved service if applicable, and the process for appeal.

Denial rationale will include the specific clinical criteria or benefits provision used in the determination of the denial. Written notifications are sent in accordance with CMS and NCQA requirements to the provider and/or customer. Upon request, the provider or customer may receive a copy of the clinical criteria used in the decision.

Cigna Medicare provides opportunity for providers to discuss adverse determinations with the medical director who made the decision.

After a decision is rendered, a peer-to-peer conversation can occur with the purpose of allowing the ordering or treating provider an opportunity to discuss the case directly with the reviewer and to provide additional clinical information that may be helpful, prior to initiating a formal appeal. Prior authorization decisions cannot be altered with the peer-to-peer process. Cigna Medicare will advise the treating provider of the availability of this process when notification of the authorization denial is given.

Cigna in no way rewards or incentivizes, either financially or otherwise, clinical practitioners, utilization staff customers, clinical care managers, physician advisers or other individuals involved in conducting reviews, for issuing denials of coverage or service or inappropriately restricting care.

Prior Authorization Requests and Time Frames

Emergency

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average

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knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the life or health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions;
- Or, serious dysfunction of any bodily organ or part.

Prior Authorization is not required for an Emergency Medical Condition.

Expedited

An expedited request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the customer's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined and notification will occur within 72 hours of receipt of the request or as soon as the customer's health condition requires.

In order to assist us in best meeting our customer's urgent needs, it is recommended that expedited requests be reserved for services meeting the above criteria and not utilized as a convenience due to a scheduled service.

An expedited request may not be requested for cases in which the only issue involves a claim for payment for services that the customer has already received.

Routine

A routine or standard Prior Authorization request will be determined and notification will occur as expeditiously as the customer's health condition requires, but no later than 14 calendar days after receipt of the request.

Denial or Adverse Organization Determination

An Advanced Beneficiary Notice (ABN) may not be used to hold customers liable for services unless a preservice adverse organization determination has already been rendered and communicated in writing via an Integrated Denial Notice (IDN) or the customer's EOC clearly excludes the service from covered services.

Retrospective Review

Retrospective Review is the process of determining coverage for clinical services by applying guidelines/ criteria to support the claim adjudication process after the opportunity for Precertification or Concurrent Review timeframe has passed. The only scenarios in which retrospective requests can be accepted are:

- Authorizations for claims billed to an incorrect carrier.
 - As long as you have not billed the claim to Cigna and received a denial, you can request a retro authorization from Health Services within 2 business days of receiving the RA from the incorrect carrier.

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- If the claim has already been submitted to Cigna and you have received a denial, the request for retro authorization then becomes an Appeal and you must follow the guidelines for submitting an Appeal.
- Cigna will retrospectively review any medically necessary services provided to Cigna customers after hours, holidays, or weekends. Cigna does require the retro authorization request and applicable clinical information to be submitted to the Health Services department within 1 business day of the start of care.
- In accordance with Cigna policy, retrospective requests for authorizations not meeting the scenarios listed above will not be accepted and claims may be denied for payment.

Drugs/Biologics Part B (Medical Benefit)

Drugs/Biologics Part B are covered under the medical benefit in accordance with Medicare Benefit Policy Manual, Chapter 15 and Medicare Managed Care Manual, Chapter 4. Requests for Drugs/Biologics Part B precertification are processed in accordance with Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. Precertification requirements for Drugs/Biologics Part B are available at Authorization Requirements. Drugs/Biologics Precertification Form can be obtained here. Precertification requirements ensure appropriate drug utilization by following Centers for Medicare and Medicaid Services (CMS) guidelines according to National Coverage Determinations, Local Coverage Determinations, Medicare Benefit Policy Manual and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Convenient ways to obtain precertification for Part B:

- Cigna Provider Portal/HS Connect – The electronic system is the fastest and most convenient way to enter and obtain precertification. The electronic system can be accessed here.
- By calling the Drugs/Biologics Part B Precertification department at **1-888-454-0013**.
- By faxing the Drugs/Biologics Part B Precertification department at **1-877-730-3858**.

Drugs/Biologics Part B administered “incident” to physician service must be billed by the provider or facility. Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary.

Drugs/Biologics Part B may be administered and a backdated authorization obtained in cases of emergency (Definition of emergency services and retroactive authorization request timelines are in accordance with the provider manual).

Home Health Services

Cigna requires authorization of home health services. Timely receipt of clinical information supports the clinical review process. Failure to comply with notification timelines or failure to provide timely clinical documentation to support the need for home health services or continuation of home health services could result in an adverse determination. Cigna's nurses, utilize CMS guidelines and nationally accepted, evidence-based review criteria to conduct medical necessity review of services.

A Cigna Medical Director reviews all home health services that do not meet medical necessity criteria and issues a determination. If the Cigna Medical Director deems that the services are not medically necessary, the Medical Director will issue an adverse determination (a denial).

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The Prior Authorization Nurse or designee will notify the provider and customer verbally and in writing of the adverse determination via notice of denial.

Cigna will issue a NOMNC to the home health provider when an adverse determination is rendered resulting in an end to all skilled disciplines in the home. It is the Home Health Provider's responsibility to deliver the written Notice of Medicare Non-Coverage (NOMNC) provided by Cigna in accordance with CMS guidelines. The home health provider is responsible for delivering the notice to the customer or their authorized representative/power of attorney (POA) at least 2 calendar days prior to the end date of the currently approved authorization, or the second to last day of service if care is not being provided daily. For services less than 2 calendar days in duration the provider is responsible to issue the NOMNC on the initial visit. A NOMNC must be delivered even if the customer agrees with the termination of services. The provider is responsible for ensuring the customer, authorized representative or POA signs the notice within the specified time frame. The NOMNC includes information on customer's rights to file a fast track Appeal.

The home health provider is required to send a copy of the signed NOMNC back to Cigna promptly in order to ensure the customer's rights to file a fast track Appeal are preserved. Receipt of the NOMNC will be monitored. Cigna validates the appropriate receipt of the NOMNC back from home health providers in accordance with CMS guidelines.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital admission, rehabilitation admission, skilled nursing facility admission or other inpatient admission in order to ensure:

- Covered services are being provided at the appropriate level of care
- Services are being administered according to the individual facility contract

Cigna requires admission notification for the following:

- Elective admissions
- ER and Urgent admissions
- Intent to Transfer to Acute Rehabilitation, LTAC and SNF as those admissions require pre-authorization
- Admissions following outpatient procedures or observation status
- Observation status
- Newborns remaining in the hospital after the mother is discharged.

Emergent or urgent admission notification must be received via fax or phone within twenty-four (24) hours of admission or next business day, whichever is later, even when the admission was prescheduled. If the customer's condition is unstable and the facility is unable to determine coverage information, Cigna requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information to hospital professionals and discharge planners. Failure to comply with

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notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

Cigna's Health Services department complies with individual facility contract requirements for Concurrent Review decisions and timeframes. Cigna's nurses, utilizing CMS guidelines and nationally accepted, evidence-based review criteria, will conduct medical necessity review. Cigna is responsible for final authorization.

Cigna's preferred method for Concurrent Review is a live dialogue between our Concurrent Review nursing staff and the facility's UM staff within 24 hours of notification or on the last covered day. If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information Cigna has available. If it is not feasible for the facility to contact Cigna via phone, facilities may fax the customer's clinical information within 24 hours of notification to:

Area	Phone	FAX
Inpatient	888-454-0013	866-234-7230
SNF/Rehab/LTAC (All markets except those noted below)	888-200-1037	855-662-7973
Delaware, Maryland, Pennsylvania, New Jersey and Washington, DC SNF/Rehab/LTAC *	Navi healthcare: 1-855-512-7005	1-866-234-7230 1-855-847-7240
Delaware, Maryland, Pennsylvania, New Jersey and Washington, DC*Navi healthcare: 1-855-512-70051-866-234-7230Texas Inpatient	N/A	1-832-553-3426
Texas SNF/Rehab/LTAC		1-832-553-3426

***Note: In Delaware, Maryland, New Jersey, Pennsylvania, and Washington, DC, Cigna has partnered with naviHealth to provide Skilled Nursing Facility (SNF) admission post-acute network management services to its customers excluding I-SNP Traditions plan customers. NaviHealth will be working with customers and their caregivers to arrange for the least restrictive, most appropriate site where a customer's health can improve most effectively.**

To obtain prior authorization, please contact naviHealth by faxing your request to **1-855-847-7240** or by calling 1-855-512-7005.

The following post-acute services remain the responsibility of Cigna:

- Long Term Acute Care (LTAC) admissions and concurrent review
- In-customer Rehabilitation Facilities (IRF) admissions and concurrent review Home Health Services for all new admissions or resumptions of care

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- *Durable Medical Equipment, Infusion Therapy, and/or Ambulance*

Following an initial determination, the Concurrent Review nurse will request additional updates from the facility on a case-by-case basis. The criteria used for the determination is available to the practitioner/facility upon request. Cigna will render a determination within 24 hours of receipt of complete clinical information. Cigna's nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a determination. Clinical update information should be received 24 hours prior to the next review date.

A Cigna Medical Director reviews all acute confinements that do not meet medical necessity criteria and issues a determination. If the Cigna Medical Director deems that the inpatient confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The Concurrent Review nurse or designee will notify the provider(s) e.g. facility, attending/ ordering provider, and customer verbally as applicable of the adverse determination via notice of denial.

Readmission

The Health Services Department will review all readmissions occurring within 30 days following discharge from the same facility, according to established processes, to assure services are medically reasonable and necessary, with the goal of high quality cost effective health care services for health plan customers. The Health Services Utilization Management (UM) staff will review acute Inpatient and Observation readmissions. If admissions are determined to be related, they may follow the established processes to combine the two confinements.

Skilled Nursing Facility Care and Levels

Unless otherwise specifically stated in your provider services agreement, patient level classification varies based upon presenting condition of the patient in conjunction with authorized services/medical necessity.

Services and supplies that are specifically excluded from SNF Consolidated Billing are excluded from the level classifications below and should be billed in accordance with CMS billing guidelines.

Standard services, which are included in all levels of care, are as follows:

- Semi-Private room
- Meals
- Provisions of enteral and parenteral nutrition
- 24 hour Nursing care and rehabilitation nursing services
- Pharmacy
- Routine Medication
- Supplies
- Pharmacy Consultation
- Standard DME (durable medical equipment)

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- Routine Oxygen
- Routine medical and surgical supplies
- Routine Laboratory Services (i.e.,) PT, PTT, CDC, UA, C & S, SMA 7 and blood glucose
- Chest x-rays, up to one per week
- Routine Doppler Studies
- Discharge planning
- Teaching, training observation by skilled nursing or rehabilitation staff
- Case Management
- Recreational Therapy
- Social Services

Note: Reimbursement will revert to Level I on days in which therapy is not provided. Therapy Logs are to be submitted to the Post-Acute Concurrent team on a weekly basis. Dates of service for which Therapy Logs have not been submitted to Health Services within 7 days of discharge, will be reimbursed at Level I rates.

Service Type	Definition
SNF Level I Rev Code 191	<p>Includes standard services listed above, and all of the following services:</p> <ul style="list-style-type: none"> • Minimum 3 hours/day direct skilled nursing intervention • No comorbidities or stable comorbidities • Assessment of vitals and body systems is required 1-2 times per day <p>Must also include one or more of the following services:</p> <ul style="list-style-type: none"> • IV infusion <ul style="list-style-type: none"> ○ pump and supplies ○ fluids for hydration • Pain management administered intramuscular (IM) or subcutaneous (SQ) • Feeding tube <ul style="list-style-type: none"> ○ Post placement ○ Enteral nutrition and related supplies
SNF Level II Rev Code 192	<p>Includes standard services listed above, Level I services, and all of the following services:</p> <ul style="list-style-type: none"> • 3-6 hours/day direct skilled nursing intervention • Active treatment of comorbidities is required • Assessment of vitals and body systems is required 2-3 times per day

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	<p>Must also include one or more of the following services:</p> <ul style="list-style-type: none"> • Wound care for the following treatments: <ul style="list-style-type: none"> ○ Surgical/amputation sites, requiring two treatments per day ○ Decubitus-Stage 2 or greater with necrotic tissue, one or more treatments per day ○ Venous stasis ulcer-Stage 2 or greater with necrotic tissue, one or more treatments per day ○ Cellulitis requiring two treatments per day ○ Burns-with grafting, requiring mechanical debridement or two treatments per day • Acute: Colostomy, ileostomy, super-pubic catheter care, peritoneal dialysis, including training and supplies • Tracheostomy - stable • IV infusion for pain management • Therapy (PT/ST/OT) <ul style="list-style-type: none"> ○ Therapy evaluations (physical, occupational, speech) as indicated within 72 hours of admission ○ Therapy treatments 45 minutes to 2 hours per day
<p>SNF Level III Rev Code 193</p>	<p>Includes standard services listed above, Level I/II services, and all of the following services:</p> <ul style="list-style-type: none"> • 3-6 hours/day direct skilled nursing intervention • Active medical care and treatment of comorbidities is required • Potential for the comorbidities to affect the treatment plan • Assessment of vitals and body systems is required 3-4 times per day <p>Must also include one or more of the following services:</p> <ul style="list-style-type: none"> • IV infusion via subclavian line, central line, PICC (includes pump, maintenance and supplies) • IV medication with an AWP less than \$100 per day all doses combined • Total Parenteral Nutrition (TPN) administration • Wound care for the following treatments: <ul style="list-style-type: none"> ○ Decubitus - Multiple Stage II sites, requiring one or more treatments per day ○ Decubitus - Stage III or greater, requiring one or more treatments per day ○ Mechanical or sharp debridement of necrotic tissue, excludes autolytic and/or enzymatic

	<ul style="list-style-type: none"> debridement Sterile packing and / or compression bandaging Drainage tubes <ul style="list-style-type: none"> ○ Pulsed lavage daily treatments, excludes whirlpool ● Tracheostomy - with suctioning up to three times per day ● Oxygen, high concentration, nebulizer, mist ● Isolation for infection control (does not include contact isolation) ● Therapy (PT/ST/OT) <ul style="list-style-type: none"> ○ Therapy evaluations (physical, occupational, speech) as indicated ○ Therapy treatments greater than 2 hours per day
SNF Level IV Rev Code 194	<p>Includes standard services listed above, Level I/II/III services, and all of the following services:</p> <ul style="list-style-type: none"> ● Intensive Care of 6-8 hours/day skilled nursing and technical intervention ● Active medical care and treatment of comorbidities is required ● Potential for the comorbidities to affect the treatment plan ● Assessment of vitals and body systems is required 4-6 times per day <p>Must also include one or more of the following services:</p> <ul style="list-style-type: none"> ● Chronic Vent Care (Includes Supplies, Blood gases, Pulse oximetry, Pulmonary testing, Pulmonary rehabilitation) ● Tracheostomy care with frequent suctioning/coughing, greater than 3 times a shift ● Administration of Chemotherapy or IV medication with an AWP greater than \$100 per day all doses combined ● Complex Wound Care & Skin Disorders <ul style="list-style-type: none"> ○ Stage IV decubitus requiring two or more treatments daily ○ Multiple wound sites requiring debridement, packing or sterile technique
SNF Level V Rev Code 199	<p>Includes standard services listed above, Level I/II/III/IV services, and all of the following services:</p> <ul style="list-style-type: none"> ● Intensive Care of 6-8 hours/day skilled nursing and technical intervention ● Active medical care and treatment of comorbidities is required ● Potential for the comorbidities to affect the treatment plan

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	<ul style="list-style-type: none"> • Assessment of vitals and body systems is required 4-6 times per day <p>Vent Care</p> <ul style="list-style-type: none"> • Vent Care for Weaning (Chronic Vent Care (Includes Supplies, Blood gases, Pulse oximetry, Pulmonary testing, Pulmonary rehabilitation, Documented weaning trials))
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SNF Notice of Medicare Non-Coverage (NOMNC)

A Cigna Medical Director reviews all ongoing Skilled Nursing services that do not meet medical necessity criteria and issues a determination. If the Cigna Medical Director deems that continued stay is not medically necessary, the Medical Director will issue an adverse determination (a denial). The Concurrent Review nurse or designee will notify the provider and customer verbally and in writing of the adverse determination via Notice of Medicare Non-Coverage (NOMNC).

Cigna will issue a NOMNC with adverse organization determinations/denials when it is anticipated that services will end and discharge is anticipated in accordance with CMS guidelines. The skilled nursing provider is responsible for delivering the notice to the customer or their authorized representative/power of attorney (POA) at least 2 calendar days prior to the end date of the currently approved authorization. A NOMNC must be delivered even if the customer agrees with the termination of services. The provider is responsible for ensuring the customer, authorized representative or POA signs the notice within the specified time frame. The NOMNC includes information on customer's rights to file a fast track Appeal. If the provider believes continued skilled nursing services are required, a request for additional services must be submitted prior to the expiration of the existing authorization.

The skilled nursing provider is required to send a copy of the signed NOMNC back to Cigna promptly in order to ensure the customer's rights to file a fast track Appeal are preserved. Receipt of the NOMNC will be monitored. Cigna validates the appropriate receipt of the NOMNC in accordance with CMS guidelines.

The skilled nursing provider is required to send a copy of the signed NOMNC back to Cigna promptly in order to ensure the customer's rights to file a fast track Appeal are preserved. Receipt of the NOMNC will be monitored. Cigna validates the appropriate receipt of the NOMNC in accordance with CMS guidelines.

Adverse Determinations – Concurrent Review

Rendering of Adverse Determinations (Denials)

The Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits, or eligibility. Every effort is made to obtain all necessary information, including pertinent clinical information and original documentation from the treating provider to allow the Medical Director to make appropriate determinations.

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Only a Cigna Medical Director may render an adverse determination (denial) based on medical necessity. The Medical Director, in making the initial decision, may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service, or extension of stay, Cigna notifies the facility or provider's office of the denial of service. Such notice is issued to the provider and the customer, when applicable, documenting the original request that was denied and the alternative approved service, along with the process for appeal.

Cigna Medicare provides opportunity for providers to discuss adverse determinations with the medical director who made the decision.

The purpose of the peer-to-peer conversation is to allow the ordering or treating provider an opportunity to discuss the case directly with the reviewer and to provide additional clinical information that may be helpful, prior to initiating a formal appeal.

Cigna Medicare will advise the treating provider of the availability of this process when notification of the authorization denial is given.

While Medicare generally does not allow an adverse decision to be overturned in the absence of an appeal, there is an opportunity to overturn concurrent review denials via the peer-to-peer process for acute inpatient stays at contracted facilities.

The provider may initiate the peer-to-peer discussion by calling the number listed on the denial notification. The provider has three (3) business days following discharge to initiate and complete a peer-to-peer review. We will make the peer-to-peer conversation available after receiving a timely request. If the physician who issued the denial is unavailable, another physician reviewer will be available to discuss the case.

If the peer-to-peer conversation or review of additional information results in an approval, the physician reviewer informs the provider of the approval. If the conversation does not result in an approval, the physician reviewer informs the provider of the right to initiate an appeal, and explains the procedure.

Cigna employees are not compensated for denial of services. The PCP or attending physician may contact the Medical Director by telephone to discuss adverse determinations.

Notification of Adverse Determinations (Denials)

The reason for each denial, including the specific Utilization Review criteria with pertinent subset/ information or benefits provision used in the determination of the denial, is included in the written notification and sent to the provider and customer as applicable. Written notifications are sent in accordance with CMS and NCQA requirements to the provider and/or customer as follows:

- **For non-urgent pre-service/standard decisions** - within 14 calendar days of the request.
- **For urgent pre-service/expedited decisions** - *within 72 hours of receipt of the request.
- **For urgent concurrent decisions** - *within 24 hours of the request.
- **For post-service decisions** - within 30 calendar days of the request.

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Cigna complies with CMS requirements for written notifications to customers, including rights to appeal and grievances.

Discharge Planning and Acute Care Management (ACCM)

Discharge planning is a critical component of the process that begins with an early assessment of the customer's potential discharge care needs in order to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the customer and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. Cigna's ACCM staff will coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan. The Cigna ACCM nurse will facilitate the communication for all needed authorizations for services, equipment, and skilled services upon discharge.

Outpatient Observation Notice

Contracted hospitals and Critical Access Hospitals (CAHs) must implement the provisions of the **NOTICE Act**. Under the NOTICE Act, hospitals and CAHs must deliver the Medicare Outpatient Observation Notice (MOON) to any customer who receives observation services as outpatient for more than 24 hours. Details for the NOTICE Act Requirements can be located at:

<https://www.federalregister.gov/articles/2016/08/22/2016-18476/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-etc>

Referrals

Referral Guidelines

- PCPs should refer to Cigna Medicare contracted specialists
- Non-contracted Specialists visits require Prior Authorization
- Referrals must be obtained prior to Specialist services being rendered
- PCPs should not issue retroactive referrals
- Most referrals are valid for 120 days starting from the issue date
- All requests for referrals must include the following information:
 - Customer name, date of birth, customer ID
 - PCP name
 - Specialist name
 - Date of referral
 - Number of visits requested
 - ****PPO products do not require referrals****

If a customer is in an active course of treatment with a non-contracted Specialist at the time of enrollment, Cigna will evaluate requests for continuity of care. A PCP referral is not required, but an authorization must be obtained from Cigna's Prior Authorization Department. For further details, please refer to the Continuity of Care section in Health Services. Please note: If a customer needs care from a Specialist, it is preferred that he/she obtains the referral from

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his/her PCP.

Referrals Crosswalk

No referrals for contracted specialist services on HMO plans in [select](#) markets. Reference the **grid** below for details.

2021 HMO Plans – Require Specialist Referrals

Market	Specialist Referrals are required for this HMO plan
Alabama	
Arkansas	
Arizona (Phoenix)	✓
Arizona (Tucson)	✓
Central Florida (Daytona, Orlando, Sumter County, Tampa)	✓
Florida (Leon)	✓
Georgia	
Mountains States Market (Colorado Springs, Boulder, Denver & Fort Collins)	✓
Illinois	✓
Kansas City	
MAPA (Delaware, Maryland, Virginia, District of Columbia, New Jersey, & Pennsylvania)	
North Carolina	
New Mexico	
South Carolina	
Ohio	
Tennessee	
Treasure Coast	
Texas (Oklahoma City)	
Texas	✓
Utah	

PPO Products - Referrals

Referrals are **not required** for PPO products.

HMO Products - Referrals

The Primary Care Physician (PCP) is often the customer's primary point of entry into the

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health care delivery system for all outpatient Specialist care. The PCP may be required to obtain a referral for most outpatient specialist visits for Cigna customers, depending on the Product and contractual agreements. The customer's ID card will indicate if a referral is required. If you have questions on referral requirements, please contact Provider Customer Service at **1-800-230-6138**.

Requesting a Referral

Referrals can be requested through several methods, such as:

- [HS Connect](#) (Preferred method)
- Fax
- Phone
- Mail

Your Network Operations representative can provide additional details regarding the preferred method of communication in your area. Likewise, the Specialist is required to ensure that a referral is in place prior to scheduling a visit (except urgent/emergent visits, which do not require referral). The Specialist is also required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment and the need for any ongoing care.

Electronic submission/retrieval of referrals through [HS Connect](#) helps to ensure accurate and timely processing of referrals.

All referrals must be obtained prior to services being rendered. Retro-authorizations of referrals follow Cigna guidelines as listed above. Please note that we value the PCP's role in taking care of our Cigna customer and that the PCP has a very important role in directing the customer to the appropriate Specialist based on your knowledge of the customer's condition and health history. It is recommended that customers are directed to participating providers. Special circumstances such as network access or availability, must be coordinated with the plan. In order to ensure this, please refer to our online directory or contact Customer Service for assistance.

Remember: An authorization number does not guarantee payment – services must be a covered benefit. To verify benefits before providing services, call **1-800-230-6138**.

Obtaining and Verifying Referrals

Cigna's online provider portal [HSConnect](#) at <https://www.hsconnectonline.com/login.aspx> is available 24 hours a day, seven (7) days a week for referral requests. This flexibility allows data entry at any time and records the transaction for the referring specialist to verify that a referral is on file prior to the date of the visit. The PCP also has the ability to search for specialty requests for customers on his/her panel. The PCP has the responsibility of notifying the customer that the referral is approved and documenting the communication in the medical record.

For those PCPs who do not have web access, a request for a referral may be obtained by faxing or calling the Prior Authorization Department. See [Prior Authorization](#) section for details. PCPs that are having difficulty locating a contracted Provider for specialty care are encouraged to go to www.cignahealthspring.com to access our online Provider Directory. A

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referral is not a guarantee of payment. Payment is subject to eligibility on the date of service, plan benefits, limitations and exclusions under the benefit plan.

Primary Care Physician's Referral Responsibilities

A PCP is responsible for ensuring a customer has a referral prior to the appointment with the specialist.

Instructions for PCP to Obtain Referrals:

There are three ways a PCP can obtain referral to Specialists:

1. **Log in to [HSCConnect](#)** – (Preferred method)
2. **Referral Form:** Complete the referral form and fax it into our referral department.
3. **Call the Referral Department:** If the referral is an emergency, or you simply would like to speak with a referral department representative, you may obtain a referral by phone by calling:

MARKET	CONTACT
Alabama	1-800-962-3016
Mountains States Market (Colorado Springs, Boulder, Utah, Denver, Fort Collins, New Mexico)	1-800-230-6138
Florida	1-800-962-3016
Southern Mississippi (Jackson)	1-866-949-7103
Georgia (All counties excluding Catoosa, Dade, and Walker)	1-866-949-7103 or fax to: 1-855-420-4717
North Carolina	1-866-949-7099
South Carolina	1-866-949-7101
Kansas City	1-888-454-0013
Tennessee, Northern Georgia, and Arkansas	1-800-453-4464
Illinois, Ohio and Indiana	1-800-230-7298
Oklahoma City, Texas and Southern Arkansas	Cigna Precert: <ul style="list-style-type: none"> • Toll Free: 1-800-511-6932 • Local: 1-832-553-3456 • Toll Free Fax: 1-888-856-3969 • Local Fax: 1-832-553-3426 Home Health/DME: <ul style="list-style-type: none"> • Toll Free: 1-800-511-6932 • Local: 1-832-553-3313 • Toll Free Fax: 1-888-205-8658
Delaware, Maryland, New Jersey, Pennsylvania, and Washington D.C.	Phone: 1-888-454-0013 Fax: 1-866-464-0707

Specialist Physician's Referral Responsibilities

In some areas, specialists must have a referral from a PCP prior to seeing a customer. Claims may be denied if a Specialist sees a customer without a referral when the health plan requires

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a referral. Cigna is unable to make exceptions to this requirement. In order to verify that a referral has been made, the Specialist may log in to [HSCconnect](#), contact the customer's PCP, or the Specialist may call Cigna to verify.

Referrals to Non-Participating Providers

Cigna strives to ensure the quality of care delivered by our -contracted providers. Referrals to Non-contracted Providers are not recommended as the quality of care cannot be effectively monitored for our customers. Additionally, use of a non-participating provider may be excluded by the customer's benefit plan or may negatively impact the customer's applicable cost-sharing. Cigna will consider a referral to a non-participating provider only if there is a continuity of care issue, a network gap has been identified, or in medically necessary circumstances in which the customer's need cannot be met in network, (e.g., a service or procedure is not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards). Prior authorization is required for referrals to non-participating providers and requests will be reviewed for the criteria above as described in the Prior Authorization section of this manual. While it is recommended that a PCP initiate requests for authorizations to providers, customers or their authorized representatives may request on their own behalf. Standardly, PPO plans do not require an authorization for out-of-network care. However, PPO customers requiring out-of-network care meeting the network and medical necessity criteria above must also request a prior authorization to ensure the applicable customer cost-share is applied.

Part B Step Therapy

As part of the American Patients First Blueprint, Medicare Advantage plans have the option to apply step therapy for physician-administered and other Part B drugs in a way that lowers costs and improves the quality of care for Medicare beneficiaries. Step therapy is a type of prior authorization for drugs that requires the initiation of therapy for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions. The allowance of step therapy practices for Part B drugs will help achieve the goal of lowering drug prices while maintaining access to covered services and drugs for beneficiaries.

Step therapy prior authorization requirements on Part B drugs will apply to "new starts" only and will not apply for customers who are currently and actively receiving medications (customers with a paid claim within the past 365 days).

The list of Part B drugs that require step therapy is [available here](#).

Care Management

Care Management Program Goals

Cigna has published and actively maintains a detailed set of program objectives available upon request in our care management program description. These objectives are clearly stated, measurable, and have associated internal and external benchmarks against which progress is assessed and evaluated throughout the year. Plan demographic and epidemiologic data, and survey data are used to select program objectives, activities, and evaluations.

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Care Management Approach

Cigna has multiple programs in place to promote continuity and coordination of care, remove barriers to care, prevent complications and improve customer quality of life. It is important to note that Cigna treats disease management as a component of the care management continuum, as opposed to a separate and distinct activity. In so doing, we are able to seamlessly manage cases across the care continuum using integrated staffing, content, data resources, risk identification algorithms, and computer applications.

Cigna employs a segmented and individualized care management approach that focuses on identifying, prioritizing, and triaging cases effectively and efficiently. Our aim is to assess the needs of individual customers, to secure their agreement to participate, and to match the scope and intensity of our services to their needs. Results from health risk assessment surveys, eligibility data, retrospective claims data, and diagnostic values are combined using proprietary rules, and used to identify and stratify customers for case management intervention. The plan uses a streamlined operational approach to identify and prioritize customer outreach, and focuses on working closely with customers and family/caregivers to close key gaps in education, self-management, and available resources. Personalized care management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target customer groups.

Patients are discharged from active care management under specific circumstances which many include stabilization of symptoms or a plateau in disease processes, the completed course of therapy, customer specific goals obtained; or the customer has been referred to Hospice. A customer's case may be re-initiated based on the identification of a transition in care, a change in risk score, or through a referral to care management.

How to Use Services

Patients that may benefit from care management are identified in multiple ways, including but not limited to: Utilization Management activities, predictive modeling, and direct referrals from a provider. If you would like to refer a Cigna customer for care management/care coordinator services, please call the numbers listed below and listen to the prompts carefully that will direct you to Care Management:

STATE	PROVIDERS SHOULD CALL
Alabama Arkansas (Eastern) Colorado Delaware Florida Georgia (All counties excluding Catoosa, Dade, and Walker) Illinois Kansas City Maryland Mississippi New Mexico North Carolina Ohio Pennsylvania South Carolina Utah Tennessee Washington DC	1-866-382-0518, Option 2 Monday - Friday 8:00 AM - 5:00 PM CST Email: CareManagementSupport@cigna.com

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In addition, our customers have access to information regarding the program via a brochure and website and may self-refer. Our case management staff contacts customers by telephone. The customer has the right to opt out of the program. Once enrolled, an assessment is completed with the customer and a plan of care with goals, interventions, and needs is established.

Coordination with Network Providers

Cigna offers customers' access to a contracted network of facilities, primary care and specialty care physicians, behavioral health, and alcohol and substance use disorder specialists, as well as an ancillary care network. Each customer receives a provider directory annually giving in-depth information about how to find network providers in their area (by zip code and by specialty), how to select a PCP (if required), conditions under which out-of-area and out-of-network providers may be seen, and procedures for when the customer's provider leaves the network. A toll-free Customer Service telephone number is provided, and customers with questions are asked to reach out to the plan. Patients also have access to a series of web-based provider materials. Our website allows customers to search the provider directory for doctors, facilities, and pharmacies.

Our case management staff will work with you and your staff to meet the unique needs of each customer. Case managers work with customers and providers to schedule and prepare for customer visits, to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any non-clinical barriers to care. In cases where provider referrals are necessitated, case managers work closely with customers to identify appropriate providers, schedule visits, and secure transportation.

Program Evaluation

Cigna continually monitors the program, and makes changes as needed to its structure, content, methods, and staffing. Changes to the program are accompanied by policy and procedure revisions and staff training as required. The program operates under the umbrella of the plan's Quality Improvement Committee which reports to the Corporate Quality Improvement Committee. It is reviewed and updated annually in collaboration with the Quality Improvement Department. The plan's Physician Advisory Committee made up of network providers, also reviews the program and its Clinical Practice Guidelines at certain intervals and provides improvement recommendations.

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Quality Programs

Quality Improvement Organization Program Changes

Under the direction of the Centers for Medicare and Medicaid Services the Quality Improvement Organization (QIO) program allows two Beneficiary and Family-Centered Care (BFCC) QIO contractors to improve the quality of care and health outcomes delivered to individuals with Medicare. The BFCC-QIO contractors will focus on conducting quality of care reviews, discharge and termination of service appeals, and other areas of required review.

The two BFCC-QIO contractors are:

LIVANTA			
3 (DE, DC, MD, PA, VA, WV)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	888-396-4646 TTY 888-985-2660	Appeals: 855-236-2423
5 (IL, IN, MI, MN, OH, WI)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	888-524-9900 TTY 888-985-8775	Appeals: 855-236-2423
7 (IA, KS, MO, NE)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	888-755-5580 TTY 888-985-9295	Appeals: 855-694-2929
9 (AZ, CA, HI, NV,)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	877-588-1123 TTY 855-887-6668	Appeals: 855-694-2929

KePRO			
1 (CT, MA, ME, NH, RI, VT)	KePRO 5700 Lombardo Center Dr Suite 100 Seven Hills, OH 44131	888-319-8452 TTY 855-843-4776	844-878-7921
4 (AL, FL, GA, KY, MS, NC, SC, TN)	KePRO 5201 W. Kennedy Boulevard Suite 900 Tampa, FL 33609	888-317-0751 TTY 855-843-4776	844-878-7921
6 (AK, LA, NM, OK, TX)	KePRO 5201 W. Kennedy Boulevard	888-315-0636 TTY 855-843-4776	844-878-7921

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	Suite 900 Tampa, FL 33609		
8 (CO, MT, ND, SD, UT, WY)	KePRO 5700 Lombardo Center Dr Suite 100 Seven Hills, OH 44131	1-888-317-0891 TTY 855-843-4776	1-844-878-7921

Quality Care Management Program

Overview

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage organizations to have an ongoing Quality Improvement (QI) program to ensure health plans have the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The requirements for the QI program are based in regulation at 42 CFR§ 422.152.

Cigna Medicare’s QI program is dedicated to improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services.

Values

- Integrity – We always conduct ourselves in a professional and ethical manner
- Respect – We all have value and will treat others with dignity and respect
- Team Members – We recognize that employees are our main asset and encourage their continued development
- Communications – We encourage the free exchange of thoughts and ideas
- Balance – We manage both our personal and company priorities
- Excellence – We continuously strive to exceed our customers’ expectations
- Prudence – We always use the company’s financial resources wisely

Quality Principles

Cigna Medicare shall apply the guiding values described above to its oversight and operation of its products and internal systems and:

- Provide services that are clinically driven, cost effective and outcome oriented
- Provide services that are culturally informed, sensitive and responsive
- Provide services that enable customers to live in the least restrictive, most integrated community setting appropriate to meet their health care needs
- Ensure that guidelines and criteria are based on professional standards and evidence-based practices that are adapted to account for regional, rural and urban differences
- Foster an environment of quality of care and service within Cigna Medicare, the Senior Segment of Cigna and through our provider partners
- Promote customer safety as an over-riding consideration in decision-making

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The Quality Improvement program provides guidance for the management and coordination of all quality improvement and quality management activities throughout the Cigna Medicare's organization, its affiliates, and delegated entities.

The program describes the processes and resources to continuously monitor, evaluate and improve the clinical care and services provided to enrollees for both their physical and behavioral health. The program also defines the health plan's methodology for identifying improvement opportunities and for developing and implementing initiatives to impact opportunities identified.

Program Scope

The scope of the program includes:

- All aspects of physical and behavioral care including accessibility, availability, level of care, continuity, appropriateness, timeliness and clinical effectiveness of care and services provided through Cigna Medicare and contracted providers and organization
- All aspects of provider performance relating to access to care, quality of care including provider credentialing, confidentiality, medical record keeping and fiscal and billing activities
- All covered services
- All professional and institutional care in all settings including hospitals, skilled nursing facilities, outpatient and home health
- All providers and any delegated or subcontracted providers
- Management of behavioral health care and substance use disorder care and services
- Aspects of Cigna Medicare internal administrative processes which are related to service and quality of care including credentialing, quality improvement, pharmacy, health education, health risk assessments, Clinical Practice Guidelines, Utilization Management, customer safety, case management, disease management, special needs, complaints, grievances and Appeals, customer service, provider network, provider education, medical records, customer outreach, claims payment and information systems.

Goals

The primary objective of the Quality Improvement program is to promote and build quality into the organizational structure and processes to meet the organization's mission of improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services. The goals the organization has established to meet this objective are:

- Maintain an effective quality committee structure that:
 - Fosters communication across the enterprise
 - Collaboratively works towards achievement of established goals
 - Monitors progress of improvement efforts to established goals; and
 - Provides the necessary oversight and leadership reporting

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- Ensure customer care and service is provided according to established goals and metrics
- Ensure identification and analysis of opportunities for improvement with implementation of actions and follow-up as needed
- Promote consistency in quality program activities
- Ensure the QI program is sufficiently organizationally separate from the fiscal and administrative management to ensure that fiscal and administrative management does not unduly influence decision-making regarding organizational determinations and/or Appeals of adverse determinations of covered benefits
- Assure timely access to and availability of safe and appropriate physical and behavioral health services for the population served by Cigna
- Ensure services are provided by qualified individuals and organizations including those with the qualifications and experience appropriate to service customers with special needs
- Promote the use of evidence-based practices and care guidelines
- Improve the ability of all Cigna Medicare staff to apply quality methodology through a program of education, training, and mentoring
- Establish a rigorous delegation oversight process
- Ensure adequate infrastructure and resources to support the Quality Improvement program.
- Assure provider involvement in maintaining and improving the health of Cigna Medicare customers, through a comprehensive provider partnership.
- Maintain and monitor a model of care designed for Cigna Medicare's SNP customers
- Promote PHM strategies and activities to ensure holistic care for Cigna Medicare Customers

Corporate Quality Improvement Committee (CQIC)

The CQIC has oversight authority for Quality Improvement activities across the organization and is responsible for ensuring the development and implementation of Cigna Medicare's QI program Description, the Annual QI/UM/CM Work Plans, review and approval of Health Service Policies; monitoring credentialing, delegation oversight, customer Appeal activity, and reviewing clinical and service quality initiatives.

To monitor and facilitate implementation of the QI program, the CQIC has established appropriate sub- committees that provide oversight of the functions and activities within the scope of the organization's Quality Improvement program. The CQIC may also appoint and convene ad hoc work groups as indicated.

Health Care Plan Effectiveness Data and Information Set

HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) supplemental data (EMR/vendor data), and

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medical record review data. HEDIS includes measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Controlling High Blood Pressure, Breast Cancer Screening, Medication Reconciliation Post Discharge, and Colorectal Cancer Screening.

Plan-wide HEDIS measures are reported annually in June for the prior year and represent a mandated activity for health plans contracting with the Centers for Medicare and Medicaid Services (CMS). A portion of measures are designated as “hybrid” measures and plans are allowed to collect medical record data for the prior measure year during the annual Medical Record Review (MRR) project. This project typically runs from the end of January until the first week in May. Each spring, Cigna Representatives collect records from practitioner offices to impact this MRR project and establish final HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections.

All records are handled in accordance with Cigna’s privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506].

Cigna's HEDIS results are available upon request. Contact the Health Plan's Quality Improvement Department by email at StarQualityPartners@healthspring.com to request information regarding those results.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Special Needs Plans (SNP)

Background

In 2008, CMS issued the final regulation "Medicare Improvements for Patients and Providers Act of 2008," known as "MIPPA." This regulation mandated that all Special Needs Plans have a filed and approved Model of Care by January 1, 2010. The Patient Protection and Affordable Care Act reinforced the importance of the SNP Model of Care as a fundamental component by requiring NCQA review and approval.

Special Needs Plan Eligibility Criteria

Special Needs Plans (SNPs) are designed for specific groups of customers with special health care needs. Only customers meeting the following criteria may join the SNP plan. CMS defined these SNP types as follows:

The three SNP specific groups are:

1. Dual eligible SNP (D-SNP): for individuals who are eligible for Medicaid and Medicare;
2. Chronic condition SNP (C-SNP): for beneficiaries with chronic conditions; and
3. Institutional SNP (I-SNP): for beneficiaries who reside in a long-term care facility.

SNP Model of Care:

CMS mandates that each SNP type have a Model of Care (MOC). The MOC is an evidenced-

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based care management program which facilitates the early and on-going assessments, the identification of health risks and major changes in the health status of SNP customers. The SNP MOC provides structure and describes the coordination of care and benefits and services targeted to improve the overall health of our SNP customers. The MOC also serves to ensure that the unique needs of our SNP customers are identified and appropriately addressed.

The SNP MOC identifies four key care management components:

1. SNP population – provides a description of the unique characteristics of our overall and most vulnerable SNP customers.
2. Care coordination – describes our SNP staff structure, the Health Risk Assessment (HRA), Individualized Care plan (ICP), Interdisciplinary Care Team (ICT) and Care Transition process, all of which identify the services and benefits offered through this plan and are available to our SNP customers. The wide range of services is targeted to help our SNP customers achieve their optimal health and improve the connection to care
3. Provider Network – describes how providers with specialized expertise correspond to the target population in our SNP program and collaborate with the ICT and contribute to a beneficiary's ICP. It also explains how network providers use evidence-based medicine, when appropriate and care transition protocols. The SNP MOC Training is also addressed this section.

CMS (Medicare) mandates initial and annual SNP MOC training for staff and providers and documentation to reflect that SNP MOC training was completed. This is our SNP MOC condensed training. Our SNP MOC training is available [here](#) and can be completed face-face, audio, video, or by self-study. Completion of the training is required. Please ensure you complete annual SNP MOC Training and please send Cigna your attestation that you participated in the annual SNP MOC Training.

4. MOC Quality Measurement and Performance Improvement –describes the quality improvement plan and identifies goals for the SNP population; this section of the MOC includes clinical and customer satisfaction goals, as well as on-going performance evaluation of the SNP MOC.

SNP MOC Process

The Cigna SNP MOC care management process focuses on the unique needs of our SNP customers with the goal of identifying interventions, care coordination and care transition needs, barrier to care, education, early detection, and symptom management.

The MOC includes key program components, which are benefits and services provided to ensure appropriate care coordination and care management, including the following:

- Health Risk Assessment (HRA) – Cigna will conduct an HRA to identify care needs. SNP customers will have a Health Risk Assessment (HRA) completed within 90 days of enrollment and then annually, within 365 days of the last HRA.
- Individualized Care Plan (ICP) – HRA results and evidence-based clinical protocols are utilized to develop an ICP. The Interdisciplinary Care Team is responsible for the development of an ICP.

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- Interdisciplinary Care Team – An ICT is composed of key stakeholders, including the PCP and care managers. The ICT help to develop the ICP.
 - Primary Care Providers (PCPs) who treat SNP customers are core participants of the Interdisciplinary Care Team (ICT) as they are the primary care giver. However, ICT participants can also include practitioners of various disciplines and specialties, as well as community resource providers based on the customer’s individual needs. The customer may participate in the ICT meetings, as may health care providers.
- Care Transition – a change in health status could result in new care management needs. As a result, our care management teams provide support to address the specific needs of our SNP population.
 - As a provider, your participation is required for the coordination of care, care plan management and in identifying additional health care needs for our Special Needs program customers.

Cigna also utilizes risk stratification methodologies to identify our most vulnerable SNP customers. These customers include those who are frail/disabled, customers with multiple chronic illnesses and those at the end of life. The risk stratification process includes input from the provider, customer, and data analysis.

Your Participation is needed at the ICT meetings.

Cigna will invite you to participate in an ICT meeting when your SNP customer requires care management. We encourage you to participate in the ICT meeting and to collaborate in the care planning and identification of care planning goals for your SNP customer.

Cigna SNP programs are geared to support our customers and you by providing the benefits and services required and by supporting care management and customer goal self-management. Additionally, care transitions, whether planned or unplanned, are monitored, and PCPs are informed accordingly. PCP communication to promote continuity of care and ICT involvement is a critical aspect of Cigna’s care transitions protocols.

Implementation of the SNP Model of Care is supported through feedback from you, as well as systems and information sharing between the health plan, health care providers and the customer. The SNP Model of Care includes periodic analysis of effectiveness, and all activities are supported by the Stars & Quality department.

SNP Contact Information

When a SNP customer completes a Health Risk Assessment (HRA), HRA is utilized along with the customer to develop a care plan. A copy of the HRA can be obtained by calling: our Health Risk Assessment department at **1-800-331-6769** based on the HRA responses. The customer and assigned PCP will receive a copy of the customer's care plan. A copy of the HRA can be obtained by calling our Health Risk Assessment department at **1-800-331-6769**.

To discuss and/or request a copy of the care plan, refer a SNP customer for an Interdisciplinary Care Team meeting or to participate in an Interdisciplinary Care Team meeting, please contact our Case Management department by calling the applicable number below:

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State	Contact
Alabama, Georgia (All Counties excluding Catoosa, Dade, and Walker), Southern Mississippi, North Carolina, South Carolina and Northwest Florida	1-866-382-0518
Tennessee, Northern Georgia, and Eastern Arkansas	1-88-615-2709
Texas and Southwestern Arkansas	1-888-501-1116
Maryland, Delaware, Washington DC, and Pennsylvania	Providers should call: 1-877-562-4395
Delaware, Maryland, Pennsylvania, and Washington, DC only	To discuss and/or request a copy of a customer's comprehensive assessment results or care plan, refer a customer for an Interdisciplinary Care Team meeting or participate in an Interdisciplinary Care Team meeting, please contact our Care Coordination department at 1-866-487-3004.

Customer Information Closing Customer Panels

When a participating Primary Care Physician elects to stop accepting new customers, the provider's customer panel is considered closed. If a participating Primary Care Physician closes his or her customer panel, the decision to stop accepting new customers must be communicated to Cigna and must apply to all customers regardless of insurance coverage. Providers may not discriminate against Cigna customers by closing their customer panels to Cigna customers only, nor may they discriminate among Cigna customers by closing their panel to certain product lines.

Providers who decide that they will no longer accept any new customers must notify Cigna Network Management Department, in writing, at least 30 days before the date on which the customer panel will be closed or the time-frame specified in your contract.

Transmission of Lab Results

Cigna has implemented the Health Level Seven (HL7) standard messaging format the transmission of lab results data, version 2.5.1. This data is essential for HEDIS® reporting, in support of early detection and quality improvement for our customers. HL7 provides a robust and standardized approach to data exchange that is widely recognized and used in the health care industry. Where not explicitly stated otherwise, the HL7 standards are the required format for the transmission of lab results data to Cigna. A companion guide, containing additional details and instructions for submitting lab results data in this format, can be found by clicking [here](#).

Customer Information, Rights and Responsibilities Medical Record Standards

Cigna requires the following items in customer medical records:

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- Identifying information of the customer.
- Identification of all providers participating in the customer's care and information on services furnished by these providers.
- A problem list, including significant illnesses and medical and psychological conditions.
- Presenting complaints, diagnoses and treatment plans.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Information on allergies and adverse reactions (or a notation that the customer has no known allergies or history of adverse reactions).
- Information on advanced directives.
- Past medical history, physical examinations, necessary treatments, and possible risk factors for the customer relevant to the particular treatment.

Note: Unless otherwise specifically stated in your provider services agreement, medical records shall be provided promptly and at no cost to Cigna and Cigna customers. Failure to respond quickly to medical record requests may impact your future participation with us.

Programs and Services

Benefits and Services

All Cigna customers receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, Cigna makes available to each participating Primary Care Physician a list of their active customers. Along with the customer's demographic information, the list includes the name of the plan in which the customer enrolled.

Please be aware that recently terminated customers may appear on the list. (See "[Eligibility Verification](#)" section of this manual).

Cigna encourages its customers to call their Primary Care Physician to schedule appointments. However, if a Cigna customer calls or comes to your office for an unscheduled non-emergent appointment, please attempt to accommodate the customer and explain to them your office policy regarding appointments. If this problem persists, please contact Cigna Provider Customer Service number listed in the Quick Reference Guide.

Emergency Services and Care After Hours

Emergency Services

An emergency is defined by Cigna as the sudden onset of a medical condition with acute symptoms (the full definition of Emergency Services is located in your Agreement). A customer may reasonably believe that the lack of immediate medical attention could result in:

- Permanently placing the customer's health in jeopardy;
- Causing serious impairments to body functions; or
- Causing serious or permanent dysfunction of any body organ or part

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In the event of a perceived emergency, customers have been instructed to first contact their Primary Care Physician for medical advice. However, if the situation is of such a nature that it is life-threatening, customers have been instructed to go immediately to the nearest emergency room facility. Patients who are unable to contact their PCP prior to treatment have been instructed to contact their PCP as soon as is medically possible or within 48 hours after receiving care. The PCP will be responsible for providing and arranging any necessary follow-up services.

For emergency services within the service area, the PCP is responsible for providing, directing, or authorizing a customer's emergency care. The PCP or his/her designee must be available 24 hours a day, seven days a week to assist customers needing emergency services. The hospital may attempt to contact the PCP for direction.

Patients may have a copayment responsibility for outpatient emergency visits unless an admission results.

Cigna will reimburse Non-Participating Providers in accord with CMS requirements for emergency services rendered to customers if they become injured or ill while temporarily outside the service area. Patients may be responsible for a copayment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

Urgent care services

Urgent Care services are for the treatment of symptoms that are non-life threatening but that require immediate attention due to a customer's unforeseen illness, injury, or condition, it was not reasonable given the circumstances to obtain the services through Cigna's provider network, and the customer is either temporarily absent from Cigna's service or continuation area or the Cigna provider network is temporarily unavailable or inaccessible. The customer must first attempt to receive care from his/her PCP. Cigna will cover treatment at a participating Urgent Care Center without a referral.

Continuing or follow-up treatment

Continuing or follow-up treatment, except by the PCP, whether in or out of the service area, is not covered by Cigna for HMO products unless specifically authorized or approved by Cigna. Payment for covered benefits outside the service area is limited to medically necessary treatment required before the customer can reasonably be transported to a participating hospital or returned to the care of the PCP.

Excluded Services

Refer to the plans' specific Explanation of Coverage (EOC) or contact the provider customer service center for assistance.

Customer Rights

Cigna customers have certain rights of which Participating Providers must be aware:

The right to be treated with dignity and respect

Patients have the right to be treated with dignity, respect, and fairness at all times. Federal law prohibits Cigna and its Participating Providers from discriminating against customers (treat customers unfairly) because of a person's race, disability, religion, gender, sexual

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orientation, health, ethnicity, creed, age or national origin. If customers need help with communication, such as help from a language interpreter, they should be directed to call Customer Service. Customer Service can also help customers file complaints about access to facilities (such as wheel chair access). Patients can also call the Office for Civil Rights at **1-800-368-1019** or TTY/TDD **1-800-537-7697**, or the Office for Civil Rights in their area for assistance.

The right to the privacy of medical records and personal health information Federal and State law protects the privacy of customer medical records and personal health information. Cigna and its Participating Providers must keep customers' personal health information private as required under these laws. Cigna staff will make sure that unauthorized people do not see or change customer records. Generally, we will get written permission from the customer (or from someone the customer has given legal authority to make decisions on their behalf) before we can give customer health information to anyone who is not providing the customer's medical care. There are exceptions allowed or required by law, such as releasing health information to government agencies that are checking on quality of care.

The laws that protect customer privacy give them rights related to accessing information and controlling how their health information is used. Cigna is required to provide customers with a notice that informs them of these rights and explains how Cigna protects the privacy of their health information. For example, customers have the right to look at their medical records, and obtain copies of the records (there may be a provider fee charged for making copies). Patients also have the right to ask plan providers to make additions or corrections to their medical records (if customers ask plan providers to do this, they will review customer requests and figure out whether the changes are appropriate). Patients have the right to know how their health information has been given out and used for routine and non-routine purposes. If customers have questions or concerns about privacy of their personal information and medical records, they should be directed to call Customer Service. Cigna will release a customer's information, including prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.

The right to see Participating Providers, get covered services, and get prescriptions filled within a reasonable period of time

Patients will get most or all of their health care from Participating Providers, that is, from doctors and other health providers who are part of Cigna's provider network. Patients have the right to choose a Participating Provider (Cigna will work with customers to ensure they find physicians who are accepting new customers). Patients have the right to go to a women's health Specialist (such as a gynecologist) without a referral Reminder – applicable to HMO. PPO products do not require referrals. Refer to authorization section of this manual for additional guidance.

Patients have the right to timely access to their providers and to see Specialists when care from a Specialist is needed. Patients also have the right to have timely access to their prescriptions at any network pharmacy. Timely access means that customers can get appointments and services within a reasonable amount of time. The Evidence of Coverage explains how customers access Participating Providers to get the care and services they need, and their rights to receive care for a medical emergency and urgently needed care.

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The right to know treatment choices and participate in decisions about their health care

Patients have the right to receive full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their health care. Cigna providers must explain treatment choices, planning, and health care decisions in a way that customers can understand. Patients have the right to know about all of the treatment choices that are recommended for their condition including all appropriate and medically necessary treatment options, regardless of the cost or whether they are covered by Cigna. This includes the right to know about the different medication management treatment programs Cigna offers and those in which customers may participate. Patients have the right to be told about any risks involved in their care. Patients must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice to refuse experimental treatments.

Patients have the right to receive a detailed explanation from Cigna if they believe that a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, customers must request an initial decision. Initial decisions are discussed in the customers' Evidence of Coverage.

Patients have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. This also includes the right to stop taking their medication. If customers refuse treatment, they accept responsibility for what happens because of refusing treatment.

The right to make complaints

Patients have the right to make a complaint if they have concerns or problems related to their coverage or care. Patients or an appointed/authorized representative may file appeals, grievances, concerns and Coverage Determinations. If customers make a complaint or file an appeal or Coverage Determination, Cigna must treat them fairly and is prohibited from discriminating against them because they made a complaint or filed an appeal or Coverage Determination. To obtain information relative to appeals, grievances, concerns and/or Coverage Determinations, customers should call Customer Service.

The right to obtain information about their health care coverage and cost

The Evidence of Coverage tells customers what medical services are covered and what they have to pay. If they need more information, they should be directed to call Customer Service. Patients have the right to an explanation from Cigna about any bills they receive for services not covered by Cigna. Cigna must tell customers in writing why Cigna will not pay for or allow them to get a service, and how they can file an appeal to ask Cigna to change this decision. Provider's staff should inform customers on how to file an appeal, if asked, and should direct customers to review their Evidence of Coverage for more information about filing an appeal.

The right to obtain information about Cigna, plan providers, drug coverage, and costs

Patients have the right to obtain information about the Cigna plans and operations. This includes information about our financial condition, about the services we provide, and about our health care providers and their qualifications. Patients have the right to know how we pay our doctors. To obtain any of this information, customers should be directed to call Customer Service. Patients have the right to obtain information from us about their Part D prescription coverage. This includes information about our financial condition and about our network pharmacies. To obtain any of this information, staff should direct customers to call Customer Service.

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The right to receive more information about customers' rights

Patients have the right to receive information about their rights and responsibilities. If customers have questions or concerns about their rights and protections, they should be directed to call Customer Service. Patients can also get free help and information from their State Health Insurance Assistance Program (SHIP). Additionally, customers can obtain a free copy of the Customer Medicare Rights and Protections booklet by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

Patients can call 24 hours a day, 7 days a week, or customers can visit www.medicare.gov to order this booklet or print it directly from their computer.

The right to take action if a customer thinks they have been treated unfairly or their rights are not being respected

If customers think they have been treated unfairly or their rights have not been respected, there are options for what they can do.

- If customers think they have been treated unfairly due to their race, color, national origin, disability, age, or religion, we must encourage them to inform us immediately. They can also call the Office for Civil Rights in their area.
- For any other kind of concern or problem related to their Medicare rights and protections described in this section, customers should call Customer Service. Patients can also get help from their State Health Insurance Assistance Program (SHIP).

Advance Medical Directives

The Federal Patient Self-Determination Act grants customers the right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by the Centers for Medicare & Medicaid Services (CMS), and our own policies and procedures, Cigna requires all Participating Providers to have a process in place pursuant to the intent of the Patient Self Determination Act.

All providers contracted directly or indirectly with Cigna may be informed by the customer that the customer has executed, changed or revoked an advance directive. At the time a service is provided, the provider should ask the customer to provide a copy of the advance directive to be included in his/her medical record.

Providers are required to document in a prominent place of a customer's medical record whether the customer has executed an advanced directive.

If the Primary Care Physician (PCP) and/or treating provider cannot as a matter of conscience fulfill the customer's written advance directive, he/she must inform the customer and Cigna. Cigna and the PCP and/or treating provider will arrange for a transfer of care. Participating Providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in The Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience.

To ensure providers maintain the required processes to advance directives, Cigna conducts periodic customer medical record reviews to confirm that required documentation exists.

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Customer Responsibilities

Along with certain rights, there are also responsibilities associated with being a customer of Cigna.

Patients are responsible for the following:

- Becoming familiar with their Cigna coverage and the rules they must follow to get care as a customer. Patients can use their Cigna Evidence of Coverage and other information that we provide them to learn about their coverage, what we have to pay, and the rules they need to follow. Patients should call Cigna Patient Customer Service if they have any questions or complaints.
- Knowing which providers are part of our network because, with limited exceptions, Patients can contact the Customer Service Center at **1-800-668-3813** for assistance.
- Advising Cigna and their providers if they have other insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that they are enrolled with Cigna and presenting their plan enrollment card to the provider when possible.
- Giving their doctors and other providers the information they need to provide care for them and to follow agreed upon treatment plans and instructions. Patients must be encouraged to ask questions of their doctors and other providers whenever the customer has them.
- Paying their plan premiums and any copayments or coinsurances they may have for the Covered Services they receive. Patients must also meet their other financial responsibilities that are described in their Evidence of Coverage.
- Informing Cigna if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage, and/or Cigna operations.
- Notifying Cigna Customer Service and their providers of any address and/or phone number changes as soon as possible.
- Using their Cigna plan only to access services, medications and other benefits for themselves.

Policies

Corporate Compliance Program

Overview

The purpose of Cigna's Corporate Compliance Program is to articulate Cigna's commitment to compliance. It also serves to encourage our employees, contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Cigna's operations. Furthermore, Cigna's Corporate Compliance Program also ensures that all practices and programs are conducted in compliance with those applicable laws and regulations.

Cigna and its subsidiaries are committed to full compliance with Federal and State regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Cigna's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its customers. Cigna and its employees are also committed to meeting all contractual obligations set forth in Cigna's contracts with the Centers for Medicare & Medicaid Services (CMS). These contracts allow Cigna to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of Federal and State laws governing Cigna's lines of business, including but not limited to, health care fraud and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and, when necessary, disclosure to the appropriate governmental authorities. Cigna has in place policies and procedures for coordinating and cooperating with MEDIC (Medicare Drug Integrity Contractor), CMS, State regulatory agencies, Congressional Offices and law enforcement. Cigna also has policies that delineate that Cigna will cooperate with any audits conducted by CMS, MEDIC or law enforcement or their designees.

To report suspected or detected Medicare program non-compliance, please contact Cigna's Compliance Department at:

Cigna
Attn: Compliance Department
PO Box 20002
Nashville, TN 37202

All such communications will be kept as confidential as possible but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or other party that reports compliance concerns in good faith can do so without fear of retaliation.

You may request a copy of the Cigna Compliance program document by contacting your Cigna Provider Relationship Representative.

Fraud, Waste, and Abuse

Cigna goes to great lengths to ensure that our providers—doctors and other health care providers—are reputable and are able to provide quality care. However, there is always a possibility that a provider, or a consumer, will engage in unethical, potentially fraudulent

practices. Even a single fraudulent claim can raise the cost of health care benefits for everyone. See how you can help avoid and prevent health care fraud.

What is health care fraud?

Health care fraud is a crime. Health care fraud means to deceive another, like a private insurer, by intentionally misrepresenting or concealing a material fact(s) in order to obtain money or property, such as health care coverage or benefits. Fraud takes many forms and can include direct misrepresentations as well as half-truths and the knowing concealment of facts. Some examples of provider health care fraud are:

- Billing for services not actually performed; billing for drugs not actually dispensed
- Falsifying a patient's diagnosis to justify tests, surgeries, or other procedures that aren't medically necessary; billing for a higher quantity of drugs than was actually dispensed
- Misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery
- Upcoding—billing for a more costly service than the one actually performed
- Unbundling—billing each stage of a procedure as if it were a separate procedure
- Accepting kickbacks for patient referrals

The Special Investigations Unit (SIU) is responsible for minimizing Cigna's risk of health care fraud. The SIU partners with Cigna's Customer Service Claim Centers and others to help identify suspicious claims, stop payments to fraudulent providers, and punish wrongdoers.

The SIU also works with state and federal law enforcement, regulatory agencies, and other insurance companies to detect and prevent health care fraud and assist in the pursuit of restitution and/or prosecution of health care fraud offenders.

To report potential fraud, waste or abuse (FWA), please contact Cigna's SIU at:

- By mail:
Cigna Special Investigations
900 Cottage Grove Road W3SIU
Hartford, CT 06152
- By phone:
1-800-667-7145
- By email:
specialinvestigations@cigna.com

In addition, as part of an ongoing effort to improve the delivery and affordability of health care to our customers, Cigna conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-10 and HCPCS, codes billed by our providers. The analysis allows Cigna to comply with its regulatory requirements for the prevention of FWA and to supply our providers with useful information to meet their own compliance needs in this area. Cigna will review your coding and may review medical records of providers who continue to show significant variance from their peers. Cigna strives to ensure compliance and enhance the quality of claims data, a benefit to both Cigna's medical management efforts and our provider community. As a result, you may be contacted by Cigna's contracted partners to provide medical records to conduct reviews to substantiate coding and billing.

Steps to Meet Your FWA Obligations

Review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.

Complete the mandatory online training at:

- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>
- **Web-Based Training (WBT) course:** Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training.

Medicare Advantage Program Requirements

Overview

The terms and conditions herein are included to meet federal statutory and regulatory requirements of the federal Medicare Advantage program under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program"). Provider understands that the specific terms as set forth herein are subject to modification in accordance with federal statutory and regulatory changes to the Medicare Advantage program. Such modification shall not require the consent of provider or Cigna and will be effective immediately on the effective date thereof.

Books and Records; Governmental Audits and Inspections

Provider shall permit the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to provider's performance of the Agreement and transactions related to the CMS Contract (collectively, "Records"). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit provider's Records for any particular contract period under the CMS Contract shall exist for a period of ten (10) years from the later of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the "Audit Period"). Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.

Privacy and Confidentiality Safeguards

Provider shall safeguard the privacy and confidentiality of customers and shall ensure the accuracy of the health records of customers. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription records) of customers, including, but not limited to, the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.

Patient Hold Harmless

Participating Providers are prohibited from balance billing Cigna customers including, but not limited to, situations involving non-payment by Cigna, insolvency of Cigna, or Cigna's breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than Cigna,

acting on behalf of customers for Covered Services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances or deductibles for covered services in accordance with the terms of the applicable customer's Benefit Plan, or for collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of the Provider Manual.

Non-Covered Services

Providers may only collect fees from customers for non-covered services when the customer has been provided with a standardized written Organization Determination (OD) denial notice from Cigna prior to the item or service being rendered to the customer, or if the customer's EOC clearly states the item or service is a non-covered service.

In circumstances where there is a question whether or not the plan will cover an item or service, customers have the right to request an OD prior to obtaining the service from the provider. If coverage is denied, Cigna provides the customer with a standardized written OD denial notice which states the specific reasons for the denial and informs the customer of his or her appeal rights. In absence of the appropriate Cigna OD denial notice or a clear exclusion in the EOC, the customer must be held harmless (i.e., cannot be held financially liable for the charges).

When a provider knows or believes that a service or item is not covered under the customer's benefit, and the EOC does not explicitly state the item or service as non-covered, the provider must advise the customer to request a pre-service OD from Cigna or the provider can request the OD on the customer's behalf before the provider moves forward with rendering the services, providing the item, or referring the customer to another provider for the non-covered item or service.

Providers may not issue any form or notice that advises the customer they will be responsible for the costs associated with non-covered services unless the customer has already received the appropriate pre-service OD denial notice from Cigna or the service or item is explicitly stated as a non-covered service in the EOC. Providers cannot hold a customer financially liable for services or supplies that are not explicitly stated as non-covered in the customer's EOC. Reference the Prior Authorization Department section for more information on the organization determination process.

Delegation of Activities or Responsibilities

To the extent activities or responsibilities under a CMS Contract are delegated to provider pursuant to the Agreement ("Delegated Activities"), provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Cigna; and (ii) in the event that the Cigna or CMS determine that provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable state and/or federal laws and regulations and CMS instructions, then Cigna shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Cigna. To the extent that the Delegated Activities include professional credentialing services, provider agrees that the credentials of medical professionals affiliated or contracted with provider will either be (i) directly reviewed by Cigna, or (ii) provider's credentialing process will be reviewed and approved

by Cigna and Cigna shall audit provider's credentialing process on an ongoing basis. Provider acknowledges that Cigna retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals. In addition, provider understands and agrees that Cigna maintains ultimate accountability under its Medicare Advantage contract with CMS. Nothing in this Agreement shall be construed to in any way limit Cigna's authority or responsibility to comply with applicable regulatory requirements.

Compliance with Cigna's Obligations, Provider Manual, Policies and Procedures

Provider shall perform all services under the Agreement in a manner that is consistent and compliant with Cigna's contract(s) with CMS (the "CMS Contract"). Additionally, provider agrees to comply with the Cigna Provider Manual and all policies and procedures relating to the benefit plans.

Subcontracting

Cigna maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of Cigna. Every subcontract between provider and a subcontractor shall (i) be in writing and comply with all applicable local, state and federal laws and regulations; (ii) be consistent with the terms and conditions of the Agreement; (iii) contain Cigna and customer hold harmless language as set forth in the Agreement; (iv) contain a provision allowing Cigna and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by provider to subcontractor under such subcontract; and (v) be terminable with respect to customers or benefit plans upon request of Cigna.

Compliance with Laws

Provider shall comply with all state and federal laws, regulations and instructions applicable to provider's performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for provider to perform the services under the Agreement. Without limiting the above, Provider shall comply with federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).

Program Integrity

Provider represents and warrants that provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider shall notify Cigna immediately if, at any time during the term of the Agreement, provider (or any of its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider acknowledges that provider's participation in Cigna shall be terminated if provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal

program involving the provision of health care or prescription drug services.

Continuation of Benefits

Provider shall continue to provide services under the Agreement to customers in the event of (i) Cigna's insolvency, (ii) Cigna's discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to Cigna, and, to the extent applicable, for customers who are hospitalized, until such time as the customer is appropriately discharged.

Incorporation of Other Legal Requirements

Any provisions now or hereafter required to be included in this manual by applicable federal and/or state laws and regulations or by CMS shall be binding upon and enforceable against Participating Providers and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this manual or elsewhere in your agreement.

Conflicts

In the event of a conflict between any specific provision of your agreement and any specific provision of the manual, the specific provisions of your agreement shall control.

Dispute Resolution

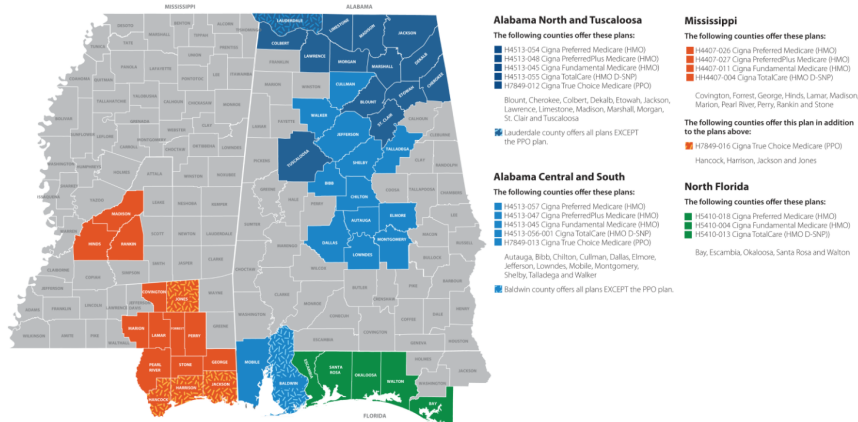
Refer to your agreement.

APPENDIX

2021 Plan Offerings/Service Maps

Alabama, Florida, and South Mississippi

Alabama, Florida, and South Mississippi Cigna 2021 Medicare Advantage Counties

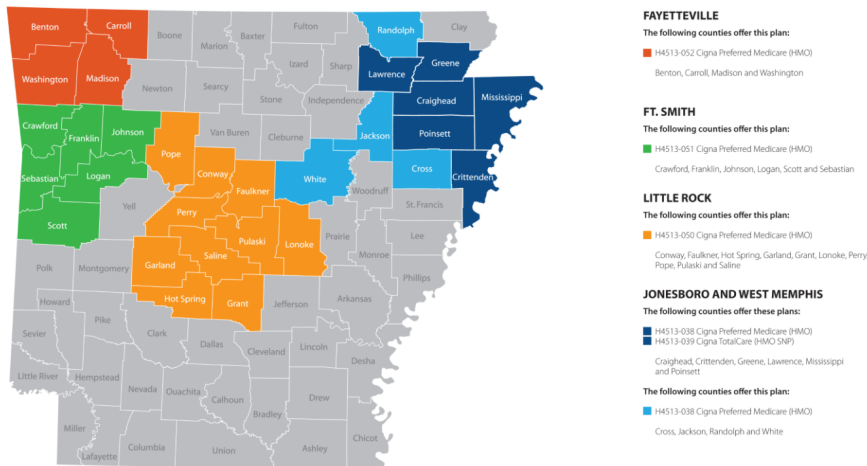


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Arkansas

Arkansas Cigna 2021 Medicare Advantage Counties

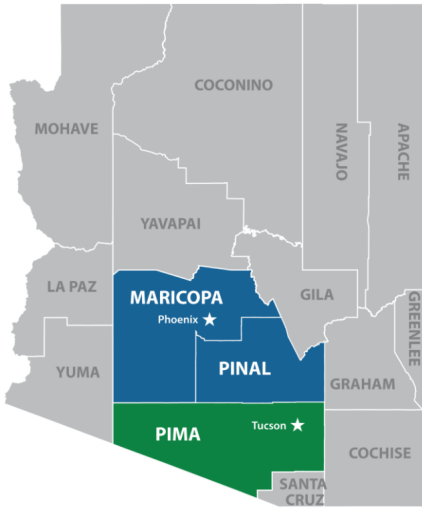


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Arizona

Arizona

Cigna 2021 Medicare Advantage Counties



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PHOENIX

The following counties offer these plans:

- H0354-001 Cigna Preferred Medicare (HMO)
- H0354-027 Cigna Achieve Medicare (HMO C-SNP)
- for people diagnosed with Diabetes
- H0354-028 Cigna Alliance Medicare (HMO)

Maricopa – Full county
Pinal – Select zip: 85117, 85118, 85119, 85120, 85140, 85143, 85178 and 85220

TUCSON

The following county offers this plan:

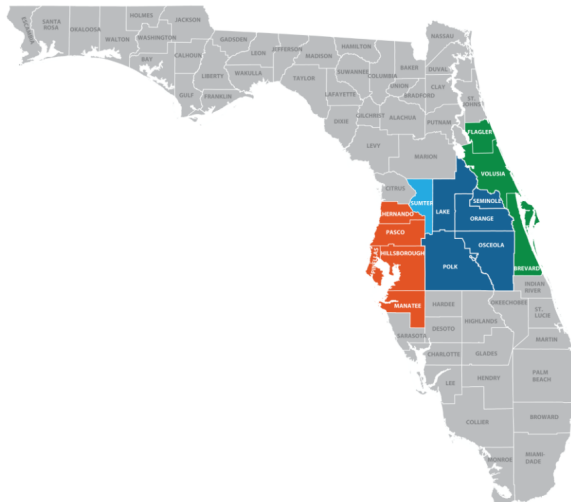
- H0354-024 Cigna Preferred Medicare (HMO)

Pima

Central Florida (Daytona, Orlando & Tampa)

Central Florida

Cigna 2021 Medicare Advantage Counties



DAYTONA BEACH

The following counties offer these plans:

- H5410-027 Cigna Preferred Medicare (HMO)
- H5410-028 Cigna Preferred Savings Medicare (HMO)
- H5410-034 Cigna Primary Medicare (HMO)
- H5410-031 Cigna TotalCare (HMO D-SNP)

Brevard, Flagler and Volusia

ORLANDO

The following counties offer these plans:

- H5410-024 Cigna Preferred Medicare (HMO)
- H5410-026 Cigna Preferred Savings Medicare (HMO)
- H5410-033 Cigna Primary Medicare (HMO)
- H5410-025 Cigna TotalCare (HMO D-SNP)
- H7849-017 Cigna True Choice Medicare (PPO)*

Lake, Orange, Osceola, Polk and Seminole
*True Choice Medicare (PPO) Not Available in Polk County

The following county offers this plan:

- H5410-036 Cigna Preferred Medicare (HMO)

Sumter

TAMPA

The following counties offer these plans:

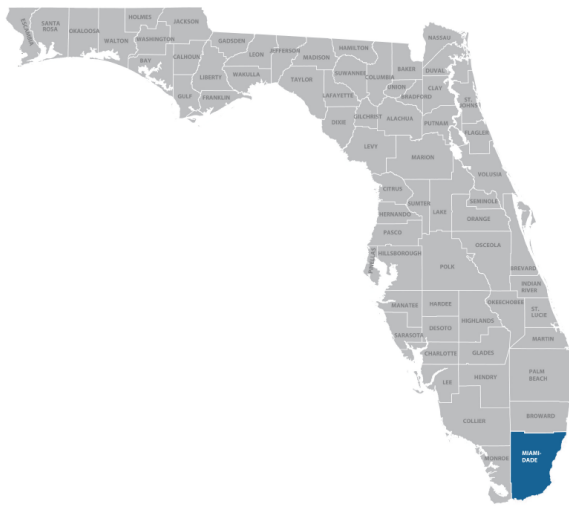
- H5410-029 Cigna Preferred Medicare (HMO)
- H5410-030 Cigna Preferred Savings Medicare (HMO)
- H5410-035 Cigna Primary Medicare (HMO)
- H5410-032 Cigna TotalCare (HMO D-SNP)

Hernando, Hillsborough, Manatee, Pasco and Pinellas

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South Florida (Leon Medical Center)

South Florida: Leon Medical Center Cigna 2021 Medicare Advantage Counties/ZIP Codes



MIAMI-DADE COUNTY (Partial)

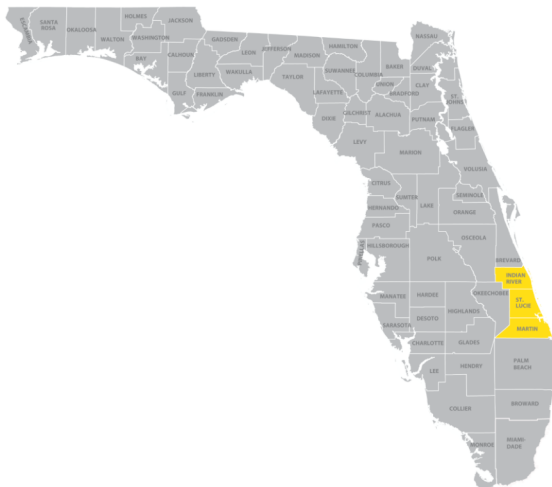
The following ZIP codes offer this plan:

■ H5410-001 Leon Medicare (HMO)

33010, 33012, 33013, 33014, 33015, 33016, 33018, 33054, 33055, 33056,
33125, 33126, 33127, 33128, 33129, 33130, 33131, 33132, 33133, 33134,
33135, 33136, 33137, 33138, 33139, 33140, 33141, 33142, 33143, 33144,
33145, 33146, 33147, 33150, 33155, 33156, 33157, 33158, 33161, 33165,
33166, 33167, 33168, 33169, 33170, 33172, 33173, 33174, 33175, 33176,
33177, 33178, 33182, 33183, 33184, 33185, 33186, 33187, 33189, 33190,
33192, 33193, 33194, 33196

South Florida East

South Florida East Cigna 2021 Medicare Advantage Counties



TREASURE COAST

The following counties offer this plan:

■ H7849-014 Cigna True Choice Medicare (PPO)

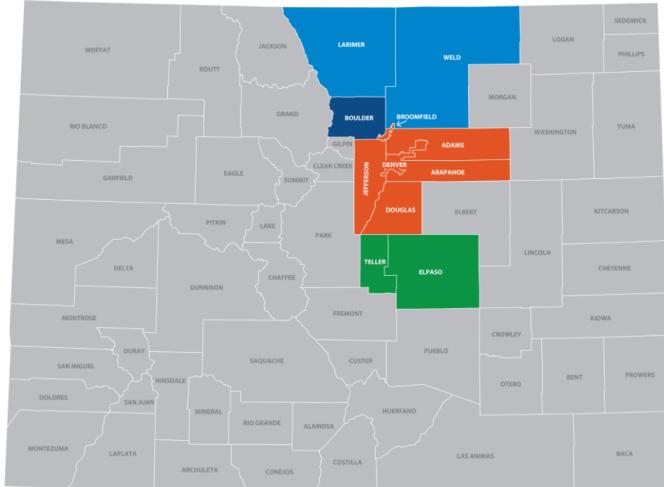
Indian River, Martin and St. Lucie

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Colorado

Colorado Cigna 2021 Medicare Advantage Counties



DENVER

The following counties offer these plans:

- H0672-001 Cigna Preferred Medicare (HMO)
- H7849-001 Cigna True Choice Medicare (PPO)

Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson

BOULDER

The following counties offer these plans:

- H0672-002 Cigna Preferred Medicare (HMO)
- H07849-001 Cigna True Choice Medicare (PPO)

Boulder

FORT COLLINS (Northern Colorado)

The following counties offer these plans:

- H0672-003 Cigna Preferred Medicare (HMO)
- H7849-026 Cigna True Choice Medicare (PPO)

Larimer and Weld

COLORADO SPRINGS (Southern Colorado)

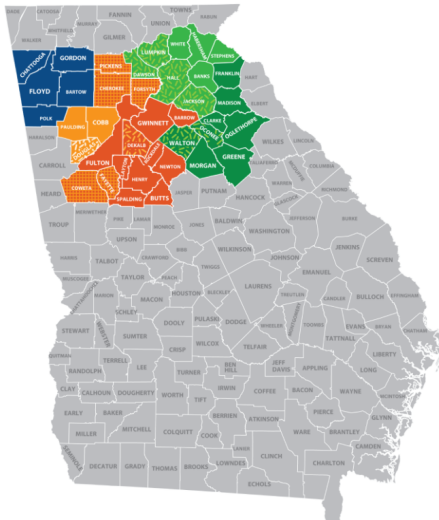
The following counties offer these plans:

- H0672-004 Cigna Preferred Medicare (HMO)
- H7849-027 Cigna True Choice Medicare (PPO)

El Paso and Teller

Georgia

Georgia Cigna 2021 Medicare Advantage Counties



GEORGIA: METRO

The following counties offer these plans:

- H0439-007 Cigna Preferred Medicare (HMO)
- H0439-006 Cigna Premier Medicare (HMO POS)
- H7849-003 Cigna True Choice Medicare (PPO)
- H0439-002 Cigna TotalCare (HMO D-SNP)

Bartow, Butts, Clayton, Fulton, Gwinnett, Henry, Newton, Rockdale and Spalding

DeKalb county does not offer the PPO plan.

The following counties offer these plans:

- H0439-007 Cigna Preferred Medicare (HMO)
- H7849-003 Cigna True Choice Medicare (PPO)
- H0439-002 Cigna TotalCare (HMO D-SNP)

Cherokee, Coweta, Fayette, Forsyth and Pickens

GEORGIA: WEST METRO

The following counties offer these plans:

- H0439-008 Cigna Preferred Medicare (HMO)
- H7849-020 Cigna True Choice Medicare (PPO)
- H0439-002 Cigna TotalCare (HMO D-SNP)

Cobb, Douglas and Paulding

Douglas County also offers:

- H0439-006 Cigna Premier Medicare (HMO POS)

GEORGIA: ATHENS

The following counties offer these plans:

- H0439-009 Cigna Preferred Medicare (HMO)
- H0439-006 Cigna Premier Medicare (HMO POS)
- H0439-002 Cigna TotalCare (HMO D-SNP)

Clarke, Franklin, Greene, Madison, Morgan and Oglethorpe

The following counties offer this plan in addition to the plans above:

- H7849-021 Cigna True Choice Medicare (PPO)

Oconee and Walton

GEORGIA: NORTHEAST

The following counties offer these plans:

- H0439-010 Cigna Preferred Medicare (HMO)
- H0439-002 Cigna TotalCare (HMO D-SNP)

Banks, Habersham, Stephens and White

The following counties offer this plan in addition to the plans above:

- H7849-022 Cigna True Choice Medicare (PPO)

Dawson, Hall, Jackson and Lumpkin

GEORGIA: NORTHWEST

The following counties offer these plans:

- H0439-011 Cigna Preferred Medicare (HMO)
- H7849-023 Cigna True Choice Medicare (PPO)
- H0439-002 Cigna TotalCare (HMO D-SNP)

Bartow, Chattooga, Floyd, Gordon and Polk

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Illinois

Illinois

Cigna 2021 Medicare Advantage Counties



ILLINOIS

The following counties offer these plans:

- H1415-024 Cigna Preferred Medicare (HMO)
- H1415-021 Cigna Premier Medicare (HMO-POS)
- H1415-013 Cigna Fundamental Medicare (HMO)
- H7849-002 Cigna True Choice Medicare (PPO)

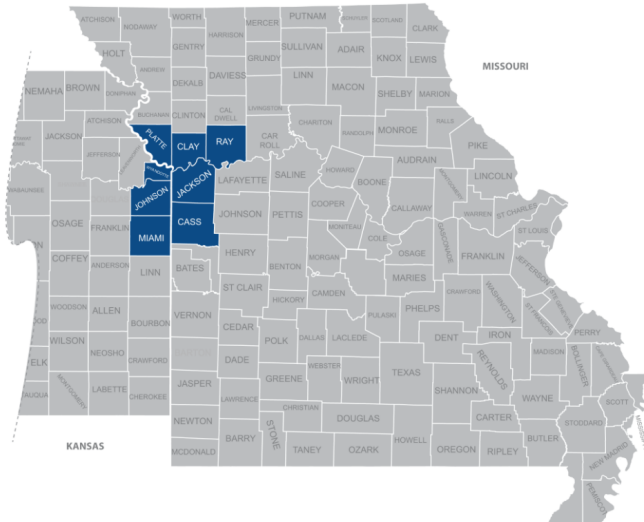
Cook, DuPage, Kane, Kankakee, Lake and Will

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Kansas City

Kansas City

Cigna 2021 Medicare Advantage Counties



KANSAS

The following counties offer these plans:

- H9460-001 Cigna Preferred Medicare (HMO)
- H7849-024 Cigna True Choice Medicare (PPO)
- H9460-002 Cigna Fundamental Medicare (HMO)

Johnson, Miami and Wyandotte

MISSOURI

The following counties offer these plans:

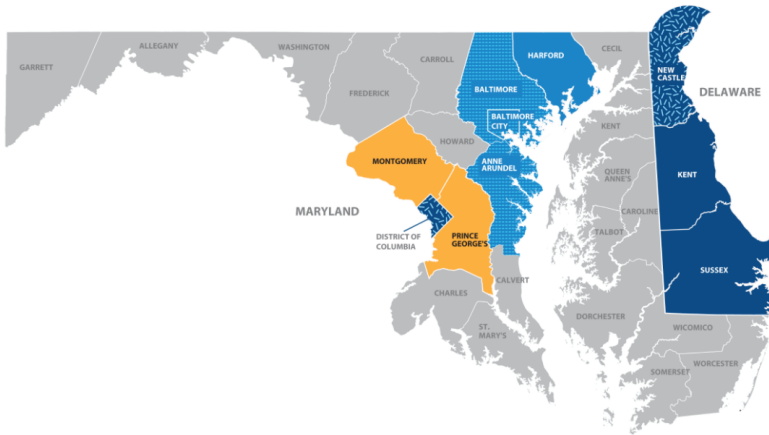
- H9460-001 Cigna Preferred Medicare (HMO)
- H7849-024 Cigna True Choice Medicare (PPO)
- H9460-002 Cigna Fundamental Medicare (HMO)

Clay, Cass, Jackson, Platte and Ray

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Mid-Atlantic

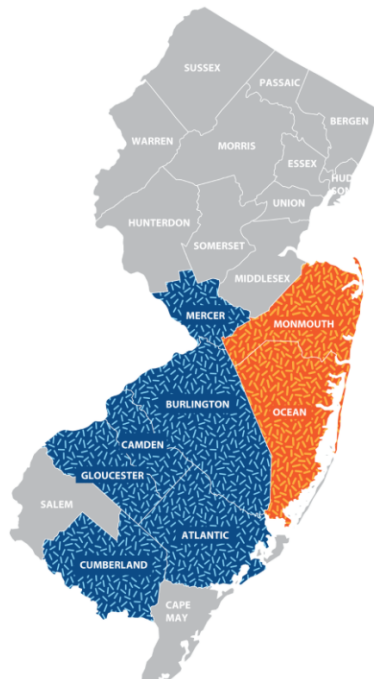
Mid Atlantic Cigna 2021 Medicare Advantage Counties



- MID ATLANTIC**
- The following counties offer these plans:**
- H2108-028 Cigna Preferred Medicare (HMO)
 - H2108-001 Cigna TotalCare (HMO D-SNP)
 - H2108-029 Cigna Achieve Medicare (HMO C-SNP)
- District of Columbia (DC), Kent (DE), New Castle (DE), Sussex (DE)
- The following counties offer these plans in addition to the ones above:**
- H7849-008 Cigna True Choice Medicare (PPO)
 - H7849-009 Cigna True Choice Plus Medicare (PPO)
- District of Columbia (DC) and New Castle (DE)
- The following counties offer these plans:**
- H2108-022 Cigna Preferred Medicare (HMO)
 - H2108-001 Cigna TotalCare (HMO D-SNP)
 - H2108-030 Cigna Achieve Medicare (HMO C-SNP)
- Anne Arundel (MD), Baltimore (MD), Baltimore City (MD), Harford (MD)
- The following counties offer this plan in addition to the ones above:**
- H2108-036 Cigna Alliance Medicare (HMO)
- Anne Arundel, Baltimore and Baltimore City (MD)
- The following counties offer these plans:**
- H2108-034 Cigna Preferred Medicare (HMO)
- Prince Georges, Montgomery (MD)

New Jersey

New Jersey Cigna 2021 Medicare Advantage Counties



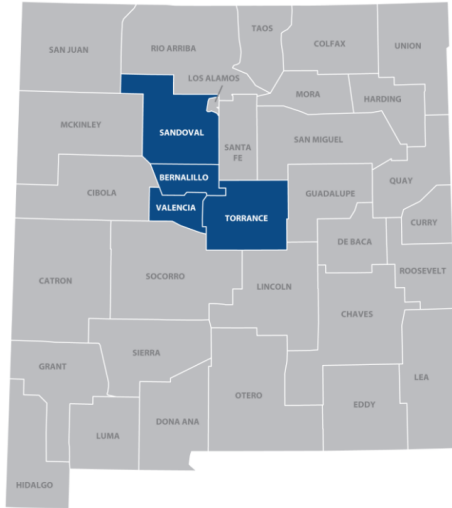
- SOUTHERN NEW JERSEY**
- The following counties offer these plans:**
- H3949-032 Cigna Preferred Medicare (HMO)
 - H3949-033 Cigna Preferred Plus Medicare (HMO)
 - H7849-033 Cigna True Choice Medicare (PPO)
- Atlantic, Burlington, Camden, Cumberland, Gloucester and Mercer
- CENTRAL NEW JERSEY**
- The following counties offer these plans:**
- H3949-034 Cigna Preferred Medicare (HMO)
 - H7849-030 Cigna True Choice Plus Medicare (PPO)
- Monmouth and Ocean

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New Mexico

New Mexico

Cigna 2021 Medicare Advantage Counties



ALBUQUERQUE

The following counties offer these plans:

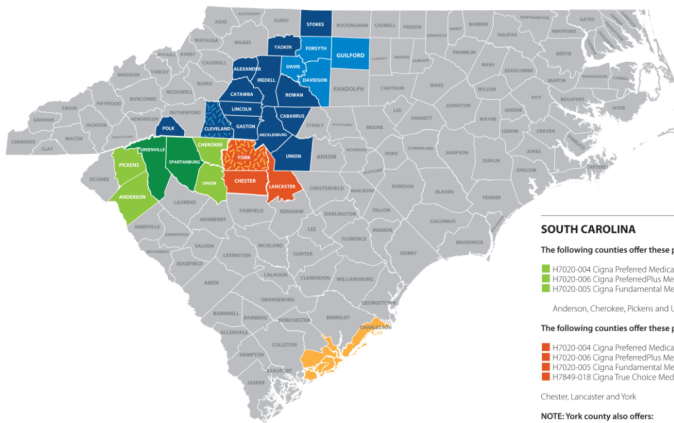
- H0672-005 Cigna Preferred Medicare (HMO)
- H7849-028 Cigna True Choice Medicare (PPO)

Bernalillo, Sandoval, Torrance and Valencia

North and South Carolina

North Carolina and South Carolina

Cigna 2021 Medicare Advantage Counties



NORTH CAROLINA

The following counties offer these plans:

- H89725-001 Cigna Preferred Medicare (HMO)
- H9725-000 Cigna PreferredPlus Medicare (HMO)
- H9725-005 Cigna Fundamental Medicare (HMO)
- H9725-003 Cigna TotalCare (HMO D-SNP)
- H7849-015 Cigna True Choice Medicare (PPO)

Alexander, Cabarrus, Catawba, Gaston, Iredell, Lincoln, Mecklenburg, Polk, Rowan, Stokes, Union and Yadkin

■ Cleveland county offers all plans above EXCEPT the PPO plan.

The following counties offer these plans:

- H9725-001 Cigna Preferred Medicare (HMO)
- H9725-006 Cigna PreferredPlus Medicare (HMO)
- H9725-005 Cigna Fundamental Medicare (HMO)
- H9725-003 Cigna TotalCare (HMO D-SNP)
- H7849-011 Cigna True Choice Medicare (PPO)

Davidson, Davie, Forsyth and Guilford

SOUTH CAROLINA

The following counties offer these plans:

- H7020-004 Cigna Preferred Medicare (HMO)
- H7020-006 Cigna PreferredPlus Medicare (HMO)
- H7020-005 Cigna Fundamental Medicare (HMO)

Anderson, Cherokee, Pickens and Union

The following counties offer these plans:

- H7020-004 Cigna Preferred Medicare (HMO)
- H7020-006 Cigna PreferredPlus Medicare (HMO)
- H7020-005 Cigna Fundamental Medicare (HMO)
- H7849-018 Cigna True Choice Medicare (PPO)

Chester, Lancaster and York

NOTE: York county also offers:

- H7020-007 Cigna Preferred Savings Medicare (HMO)

The following counties offer these plans:

- H7020-004 Cigna Preferred Medicare (HMO)
- H7020-006 Cigna PreferredPlus Medicare (HMO)
- H7020-007 Cigna Preferred Savings Medicare (HMO)
- H7020-005 Cigna Fundamental Medicare (HMO)

Greenville and Spartanburg

Charleston County offers this plan:

- H7020-008 Cigna Preferred Medicare (HMO)

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Ohio

Ohio Cigna 2021 Medicare Advantage Counties



LIBERTY VALLEY/CLEVELAND

The following counties offer these plans:

- H0672-006 Cigna Preferred Medicare (HMO)
- H7849-015 Cigna True Choice Medicare (PPO)

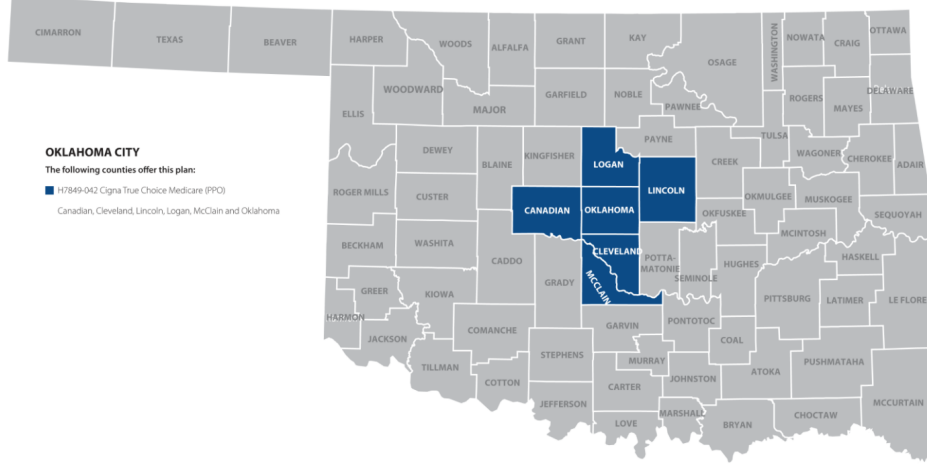
Cuyahoga, Geauga, Lake, Lorain, Medina and Summit

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3/1/2021

Oklahoma

Oklahoma Cigna 2021 Medicare Advantage Counties



OKLAHOMA CITY

The following counties offer this plan:

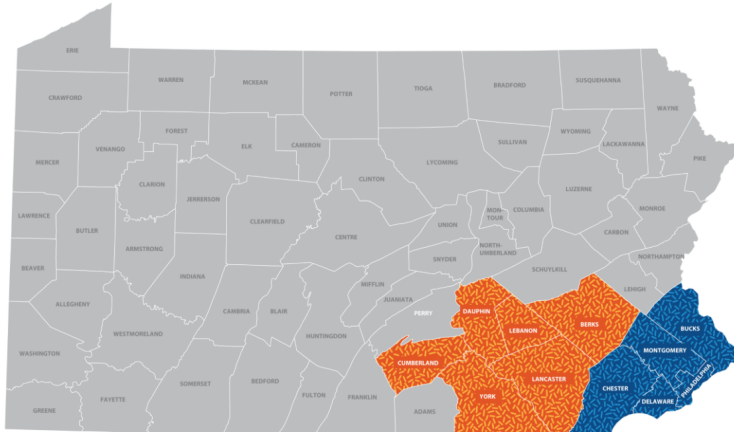
- H7849-042 Cigna True Choice Medicare (PPO)

Canadian, Cleveland, Lincoln, Logan, McClain and Oklahoma

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Pennsylvania

Pennsylvania Cigna 2021 Medicare Advantage Counties



PENNSYLVANIA

The following counties offer these plans:

- H3949-031 Cigna Alliance Medicare (HMO)
- H7849-006 Cigna True Choice Medicare (PPO)
- H3949-024 Cigna Achieve Medicare (HMO-C-SNP)
- H3949-030 Cigna Preferred Medicare (HMO)
- H7849-007 True Choice Plus Medicare (PPO)
- H3949-013 Cigna PreferredPlus Medicare (HMO)
- H3949-026 Cigna Fundamental Medicare (HMO)
- H3949-009 Cigna TotalCare (HMO D-SNP)

Bucks, Chester, Delaware, Montgomery and Philadelphia

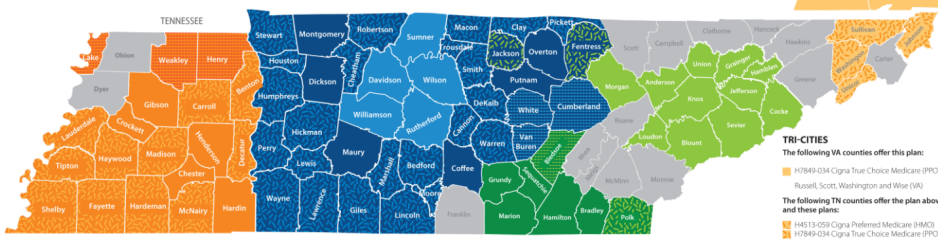
The following counties offer these plans:

- H3949-035 Cigna Preferred Medicare (HMO)
- H7849-031 Cigna True Choice Medicare (PPO)
- H7849-032 Cigna True Choice Plus Medicare (PPO)
- H3949-036 Cigna TotalCare (HMO D-SNP)

Berks, Cumberland, Dauphin, Lancaster, Lebanon and York

Tennessee, North Georgia, and Southwest Virginia

Tennessee, North Georgia and Southwest Virginia Cigna 2021 Medicare Advantage Counties



- #### WEST TENNESSEE

The following counties offer these plans:

 - H4513-049-001 Cigna Preferred Medicare (HMO)
 - H4513-033 Cigna Primary Medicare (HMO)
 - H4513-033 Cigna Fundamental Medicare (HMO)
 - H4513-034 Cigna TotalCare (HMO D-SNP)
 - H4513-036 Cigna Premier Medicare (HMO PPO)

Chester, Crockett, Gibson, Hardin and Henderson

The following counties offer all of the plans above plus this plan:

 - H7849-037 Cigna True Choice Medicare (PPO)

Benton, Carroll, Decatur, Fayette, Hardeman, Haywood, Lauderdale, McNairy, Madison, Shelby and Tipton

The following counties offer this plan:

 - H4513-049-001 Cigna Preferred Medicare (HMO)

Henry, Lake and Weakley

METRO NASHVILLE

The following counties offer these plans:

 - H4513-049-001 Cigna Preferred Medicare (HMO)
 - H4513-042 Cigna Alliance Medicare (HMO)
 - H4513-043 Cigna PreferredPlus Medicare (HMO)
 - H7849-010 Cigna True Choice Medicare (PPO)
 - H4513-034 Cigna TotalCare (HMO D-SNP)
 - H4513-036 Cigna Premier Medicare (HMO PPO)

Davidson, Rutherford (Alliance HMO plan NOT offered), Sumner, Williamson and Wilson

MIDDLE TENNESSEE

The following counties offer this plan:

 - H4513-049-002 Cigna Preferred Medicare (HMO)
 - H4513-033 Cigna Fundamental Medicare (HMO)
 - H4513-036 Cigna Premier Medicare (HMO)
 - H4513-034 Cigna TotalCare (HMO D-SNP)

Coffee, Dickson, Fentress, Jackson, Maury, Montgomery, Overton and Putnam

The following counties offer all of the plans above plus this plan:

 - H7849-010 Cigna True Choice (PPO)

Bedford, Cannon, Cheatham, Clay, DeKalb, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Macon, Marshall, Moore, Perry, Pickett, Robertson, Smith, Stewart, Trousdale, Warren and Wayne

 - H7849-036 Cigna True Choice Medicare (PPO)
 - Cumberland, Van Buren and White
 - H7849-043 Cigna True Choice Medicare (PPO)

Fentress and Jackson

KNOXVILLE

The following counties offer these plans:

 - H4513-037 Cigna Preferred Medicare (HMO)
 - H4513-035 Cigna Primary Medicare (HMO)
 - H4513-033 Cigna Fundamental Medicare (HMO)
 - H7849-043 Cigna True Choice Medicare (PPO)

Anderson, Blount, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Morgan, Sevier and Union

CHATTANOOGA and NORTH GEORGIA

The following TN counties offer these plans:

 - H4513-049-001 Cigna Preferred Medicare (HMO)
 - H4513-033 Cigna Primary Medicare (HMO)
 - H4513-033 Cigna Fundamental Medicare (HMO)
 - H4513-036 Cigna Premier Medicare (HMO PPO)
 - H7849-036 Cigna True Choice Medicare (PPO)
 - H4513-049 Cigna TotalCare (HMO D-SNP)

Bradley, Grundy, Hamilton, Marion, and Sequatchie

Bledsoe offers all plans above EXCEPT:

 - H4513-035 Cigna Primary Medicare (HMO)

Polk offers all plans above EXCEPT:

 - H4513-033 Cigna Primary Medicare (HMO)
 - H7849-033 Cigna True Choice Medicare (PPO)

The following NGA counties offer these plans:

 - H4513-030 Cigna Preferred Medicare (HMO)
 - H7849-033 Cigna True Choice (PPO)

Catoosa and Dade

The following NGA county offers this plan:

 - H4513-030 Cigna Preferred Medicare (HMO)

Walker

TRI-CITIES

The following VA counties offer this plan:

 - H7849-034 Cigna True Choice Medicare (PPO)

Russell, Scott, Washington and Wise (VA)

The following TN counties offer the plan above and these plans:

 - H4513-036 Cigna Premier Medicare (HMO)
 - H7849-034 Cigna True Choice Medicare (PPO)

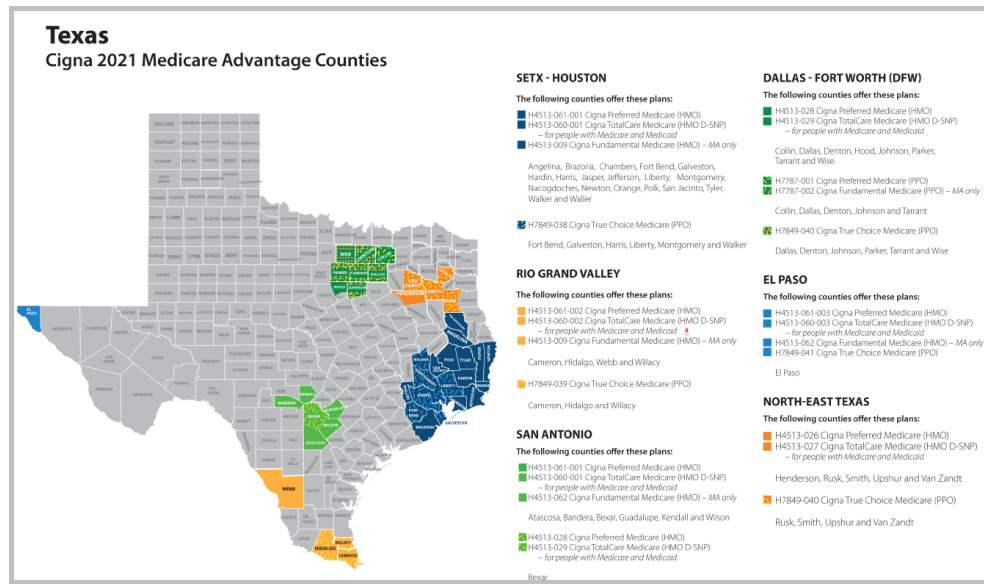
Johnson, Sullivan, Unicoi and Washington (TN)

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Texas



Utah

Utah

Cigna 2021 Medicare Advantage Counties



SALT LAKE CITY
The following counties offer this plan:
 ■ H7849-029 Cigna True Choice Medicare (PPO)
 Davis, Salt Lake, Utah and Weber

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