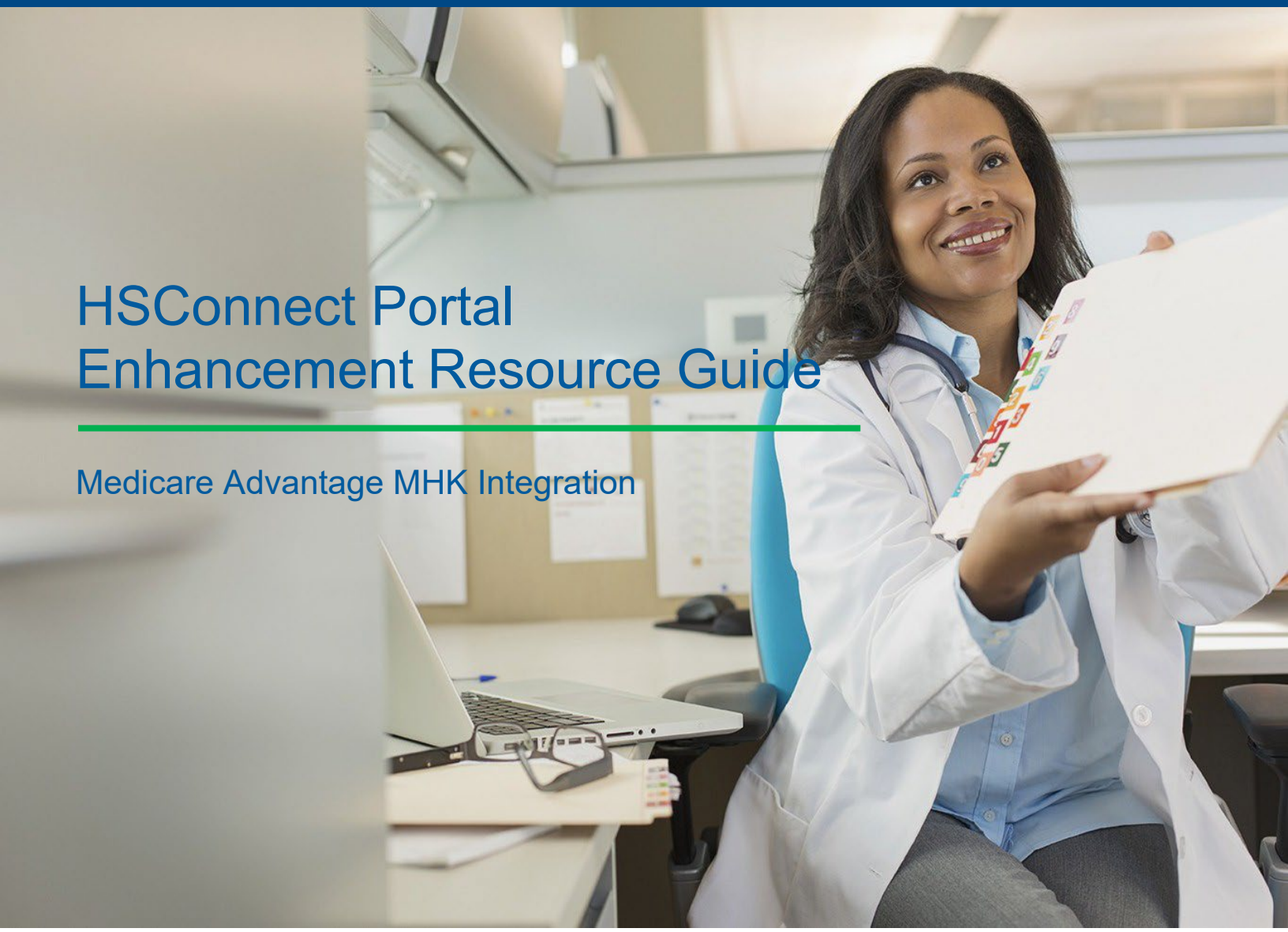


HSConnect Portal Enhancement Resource Guide

Medicare Advantage MHK Integration

Cigna®

Table of Contents

Overview

HSConnect: MHK implementation

Cigna values our partnership with our providers to deliver coordinated care to improve the health, well-being, and peace of mind of our customers. We understand our customers' needs and work with our provider partners to help your patients achieve healthier, more secure lives.

To support this commitment, in October 2020 we implemented new functionality software known as MHK, to the HSConnect Cigna Medicare Advantage provider portalto improve speed, efficiency, and transparency when accessing Cigna Medicare services like:

- Expediting approvals (some at the time of entry)
- Requesting inpatient and outpatient Medicare services electronically
- Submitting information electronically
- Attaching all required documentation of any size
- Reviewing the status of requests in real time, 24/7
- Receiving a reference number for each request
- Getting immediate access to decision letters for provider records
- Reviewing claims and payment status

To ensure you have the support you need when using HSConnect, we have created this guide to serve as a "one stop shop" for information, including answers to frequently asked questions and where to find additional resources and support.

This document will be updated periodically. Please refer to this document for the latest information.

2022 MHK Enhancements

February

- Claims search screen expansion and changes
- Sort order drop-down menus and option to expand or hide columns and fields included in the claims search results
- Ability to view in-depth patient information (e.g., copay, coinsurance, etc.) in the details of the claim

Get Started

Registration

You can register in one three ways.

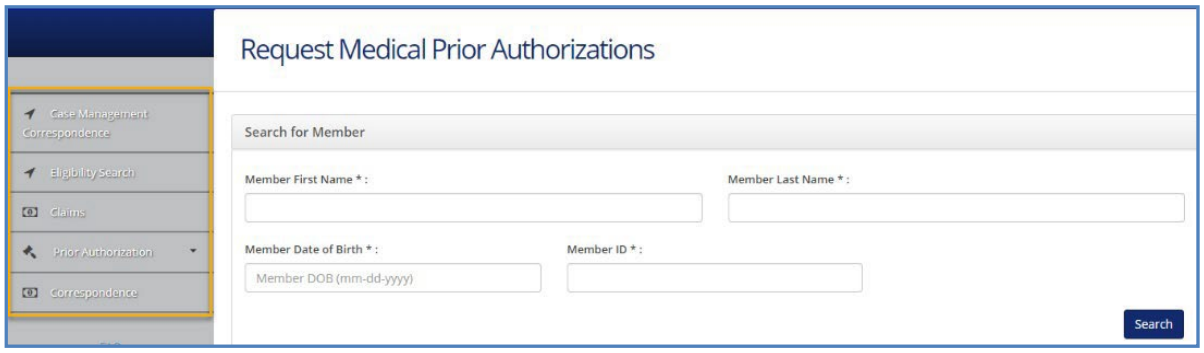
- Click here or go to the Cigna Medicare website for providers (MedicareProviders.Cigna.com) > Login to HSConnect Portal; click “Need an Account? Click here”.
- Send an email request to HSConnectHelp@HSConnectOnline.com.
- Call **866.952.7596**, option 2.

Job Aids

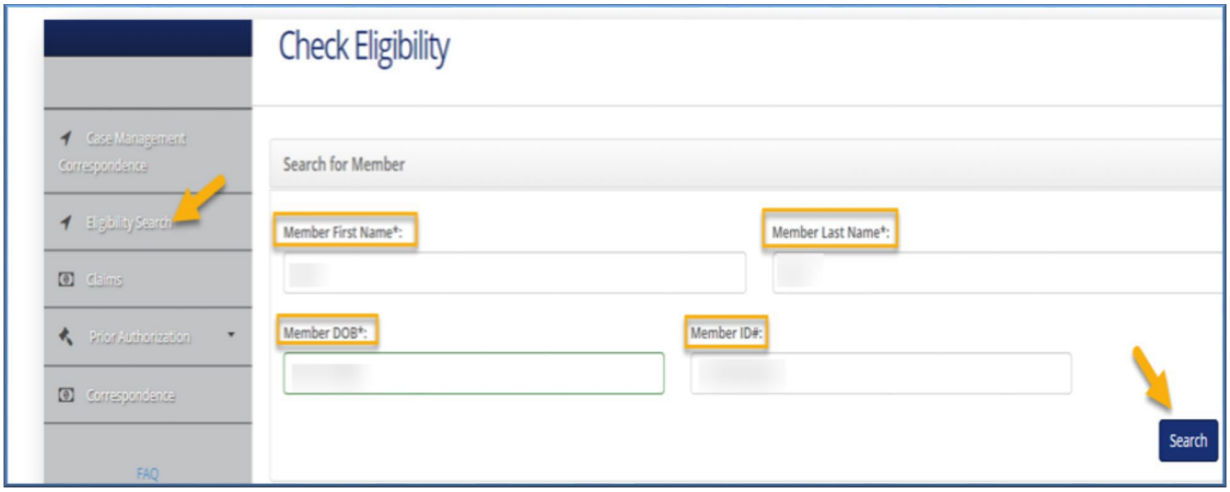
Review and verify eligibility

1. Click the link For member eligibility, authorizations, and claims search, please click here.

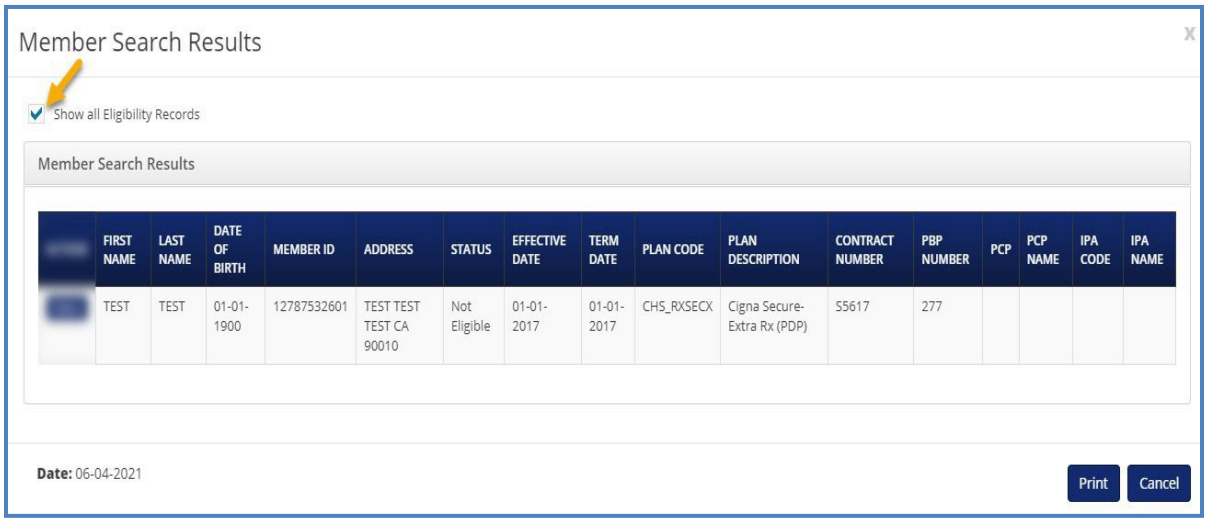
All portal functions will display.



2. Select the **Eligibility Search menu** option on the left navigation bar.
   a. All fields are required and must be entered 100% accurately.
   b. No results will populate if any data is entered incorrectly.
   c. Last name suffixes are also required.
   d. Any member IDs with an (*) must be removed.
3. Click **Search**. Search results will display.

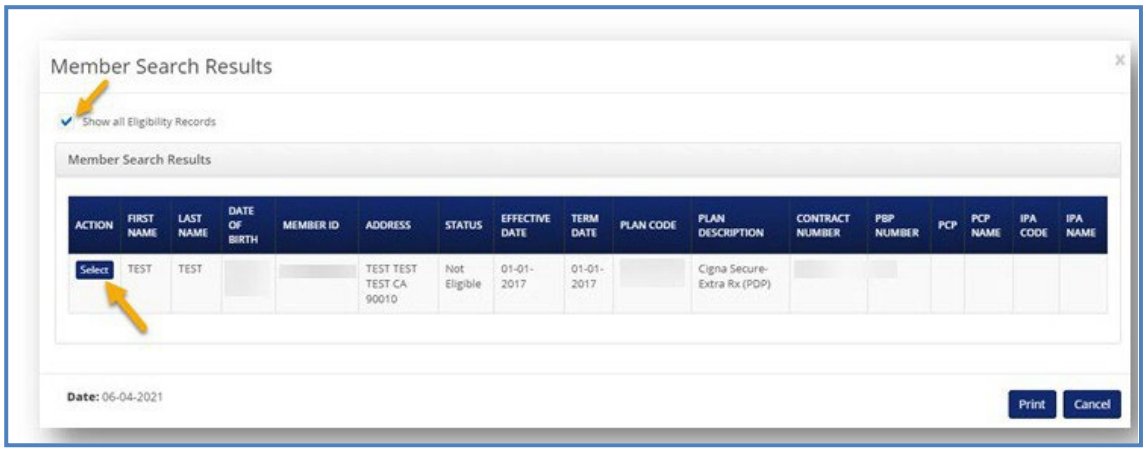


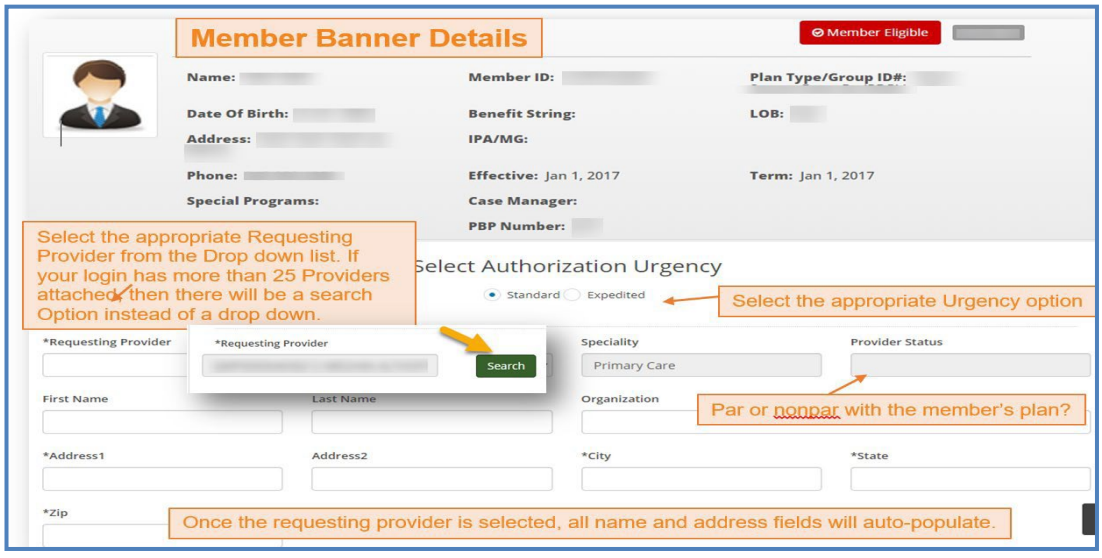
There is not currently any copayments or benefits available on the portal



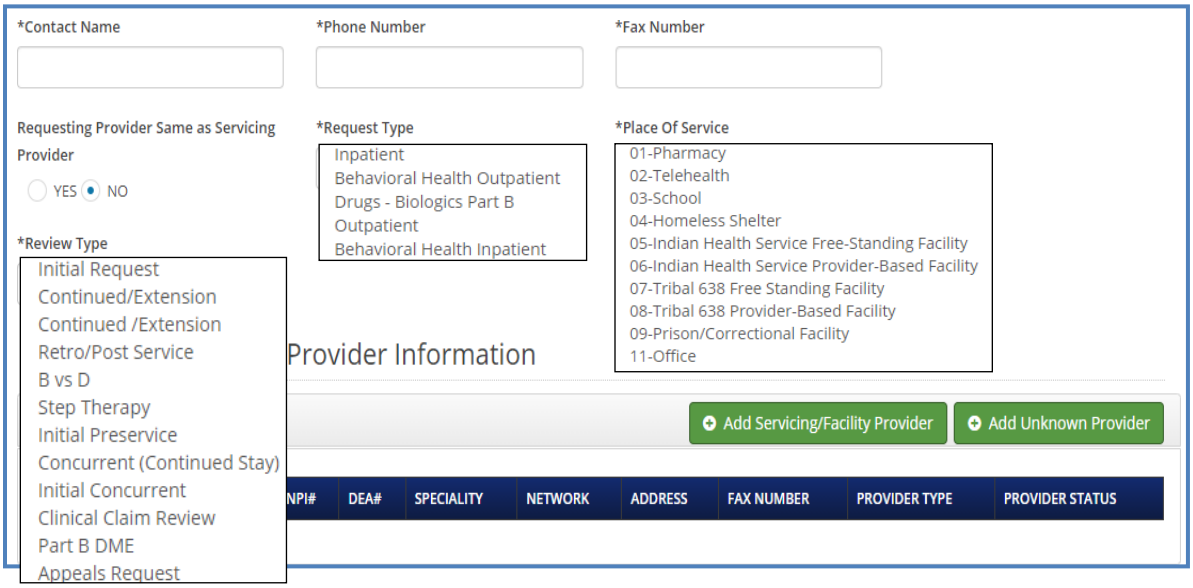
Request Authorization

1. Select the **Prior Authorization** menu option on the left navigation bar.
   a. All fields are required and must be entered 100% accurately.
   b. No results will populate if any data is entered incorrectly.
   c. Last name suffixes are also required.
   d. Any member IDs with an (*) must be removed.
2. Click **Search**. Search results will display.
3. Select the appropriate record under the **Action** column. The member details and authorization screen will display.



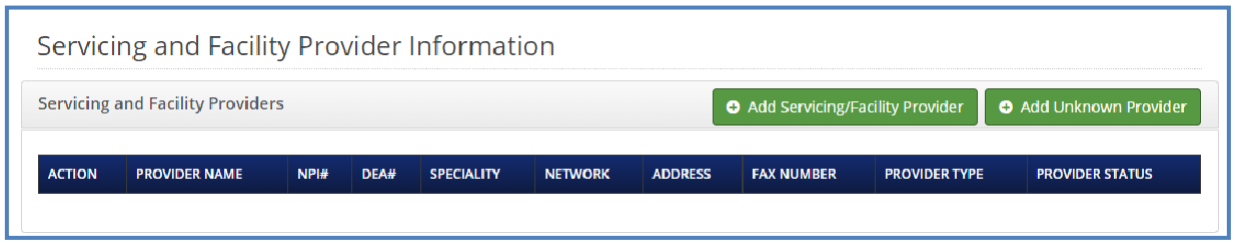


4. Complete the **prior authorization** screen. Fields with an (*) are **required**.



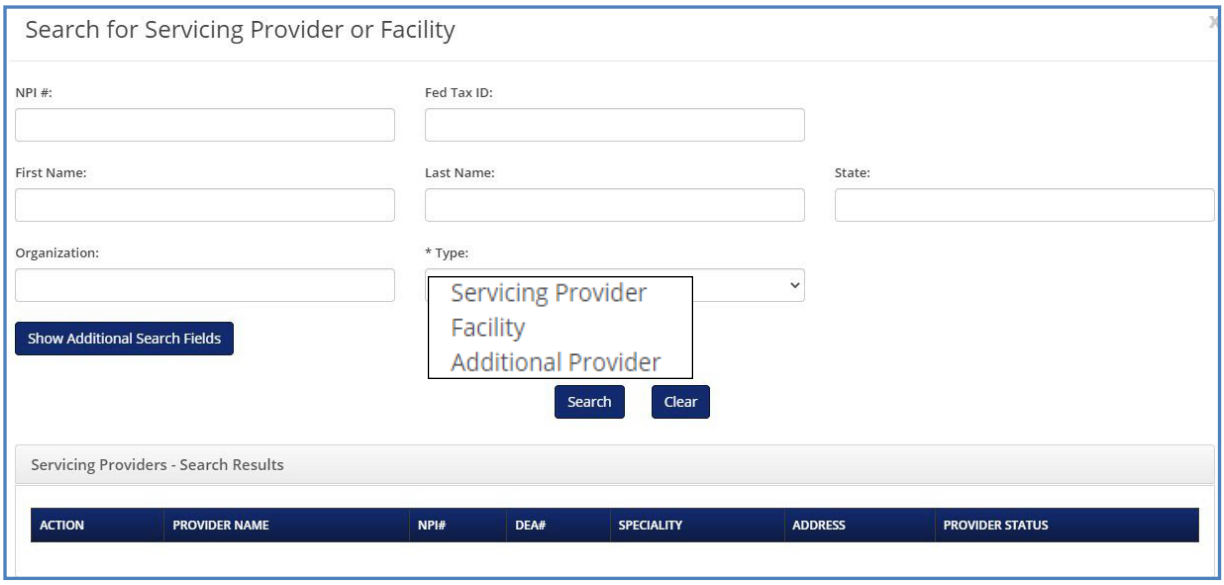
Add a Servicing Provider (Referral or Prior Authorization)

1. Click Add Servicing/Facility Provider.
2. Complete the applicable fields.



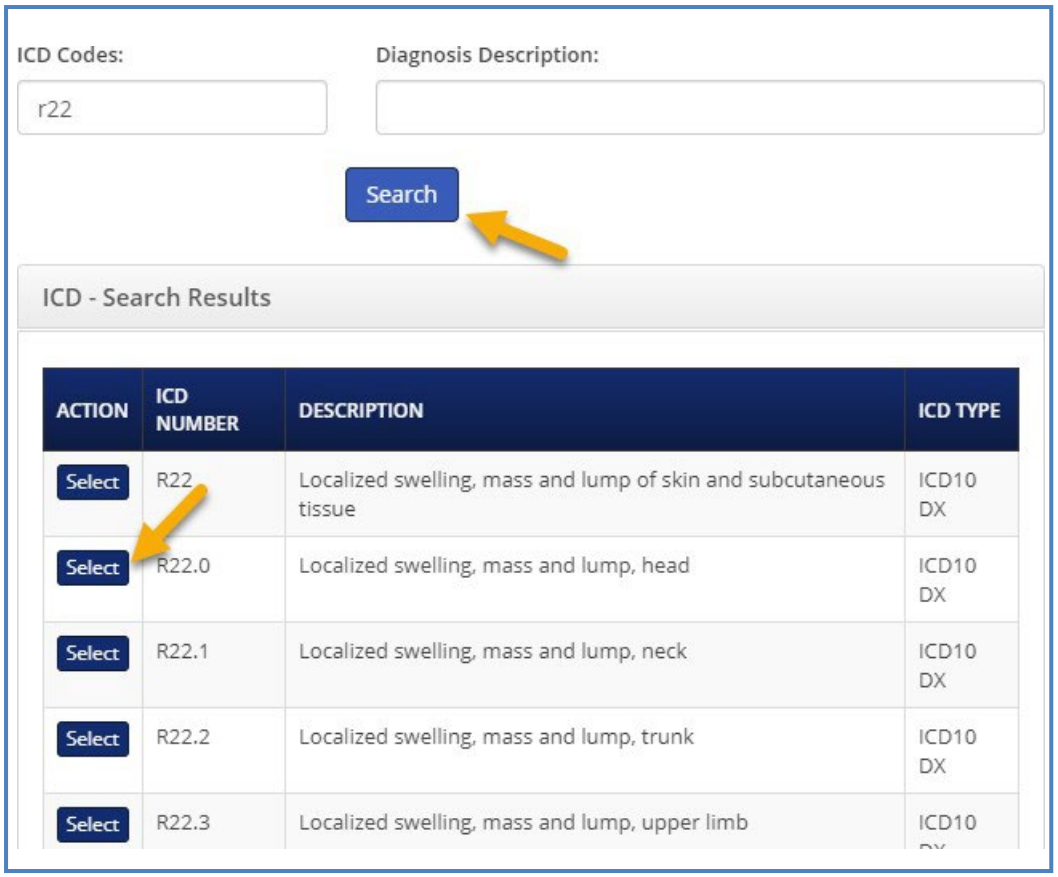
Search for Servicing Provider or Facility

1. Not all fields are required.
2. NPI search is the most common.
3. **Type field:** requires selection.



Add a Diagnosis Code (Referral or Prior Authorization)

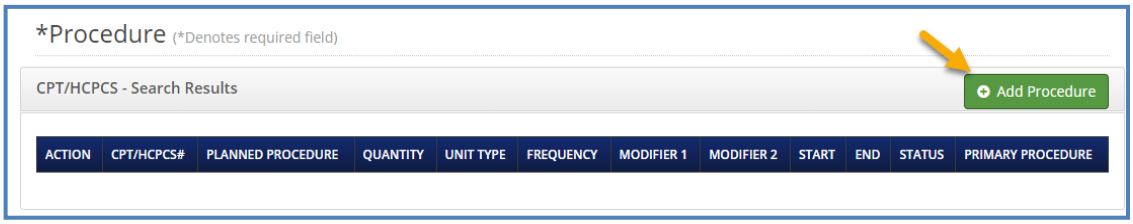
1. Click Add Primary Diagnosis.
2. Enter the appropriate code in the **ICD Codes** field.
3. Click **Search**. Codes will display.
4. Click Select next to the appropriate code under the **Action** column.

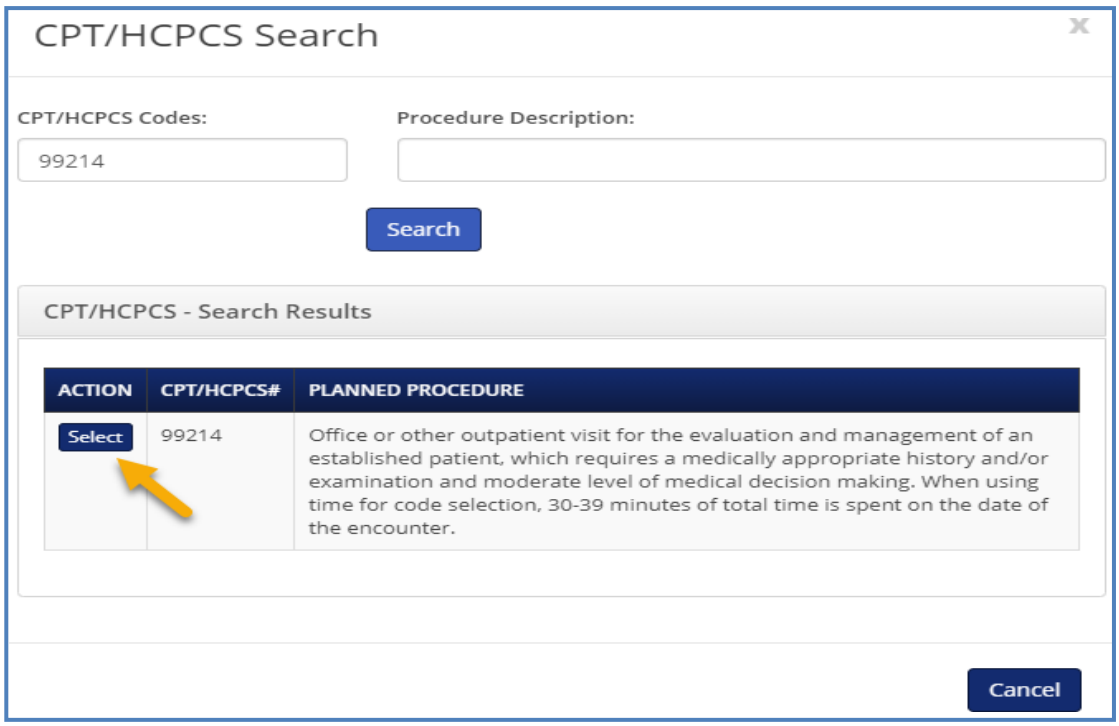


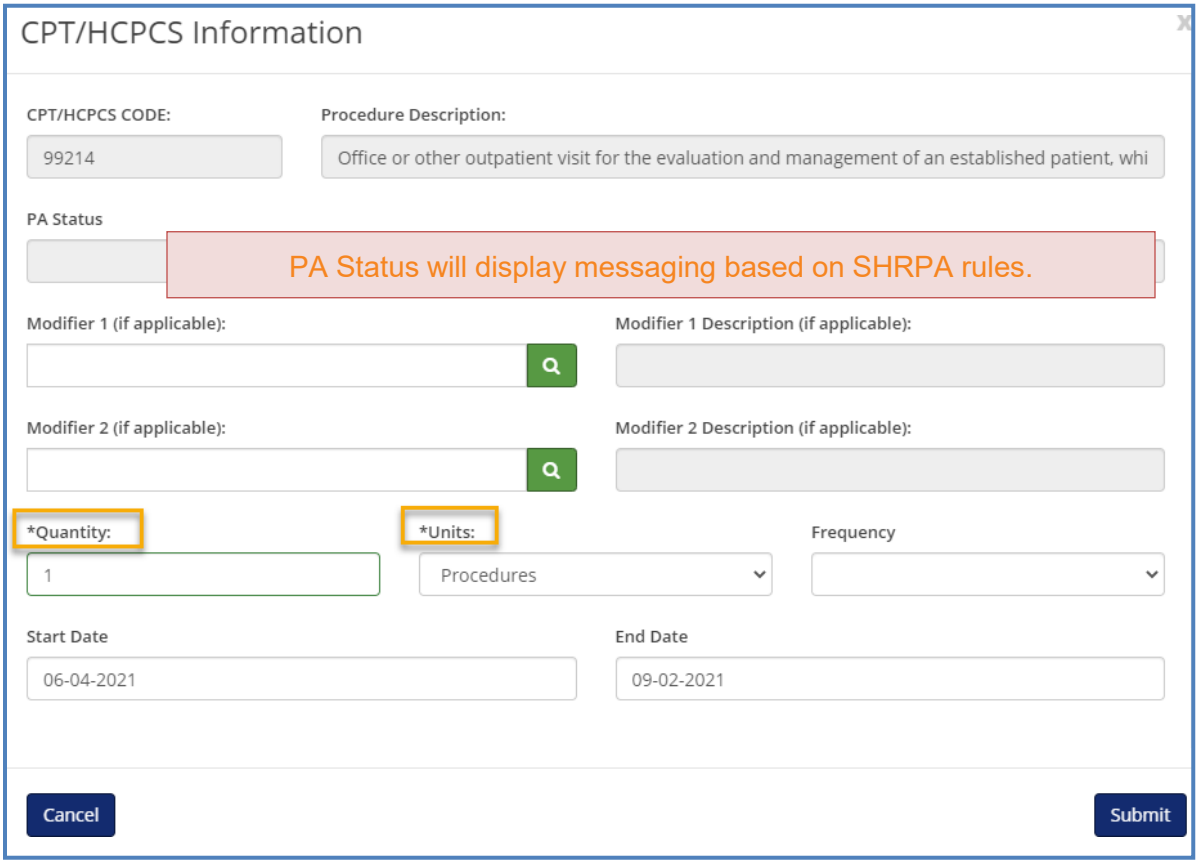
Add a Procedure Code (Referral or Prior Authorization)

Note: All previous fields must be completed before proceeding.

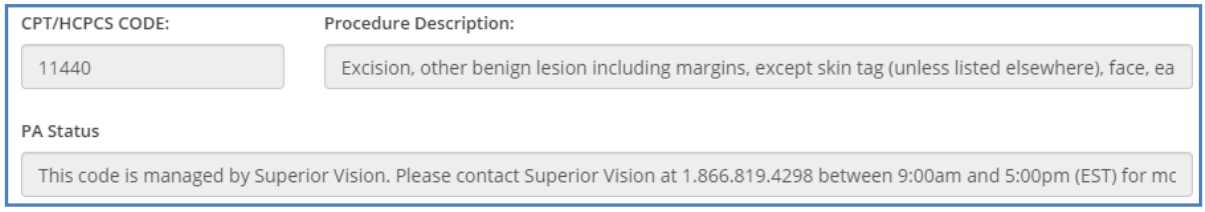
1. Click **Add Procedure**.
2. Enter the appropriate code in the **CPT/HCPCS Codes** field.
3. Click **Search**. Procedure codes will display.
4. Click **Select** next to appropriate procedure under the **Action** column. The CPT/HCPCS information will display.





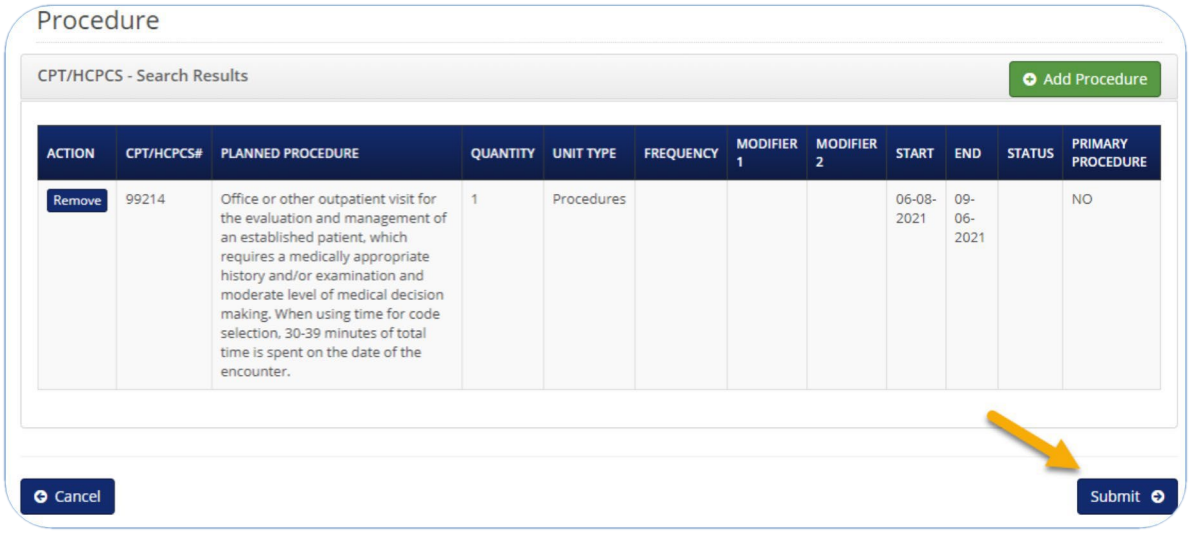


Example of PA Status messaging

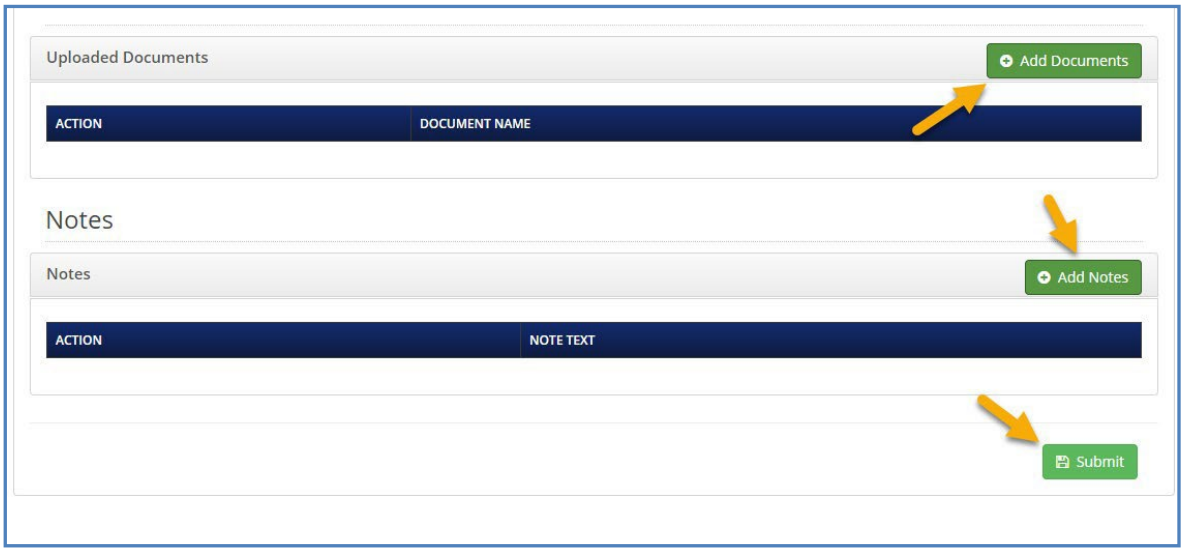


Submit a Request (Referral or Prior Authorization)

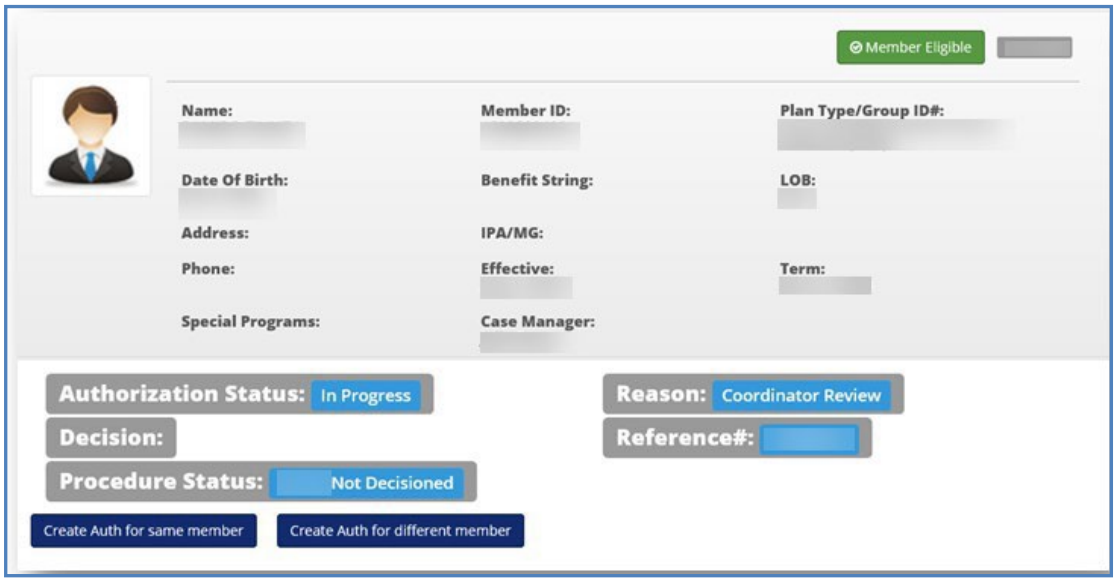
1. Click **Submit** once authorization fields are complete.



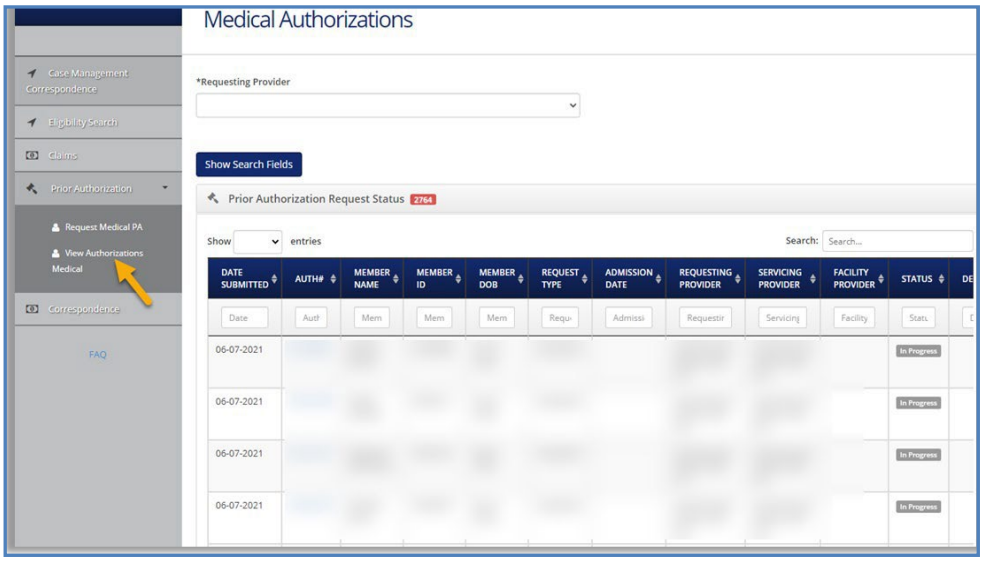
2. Upload clinical documentation or enter notes in the **Notes** field.
3. Click **Submit**.



Upon submission you will receive the authorization ID, status, etc.



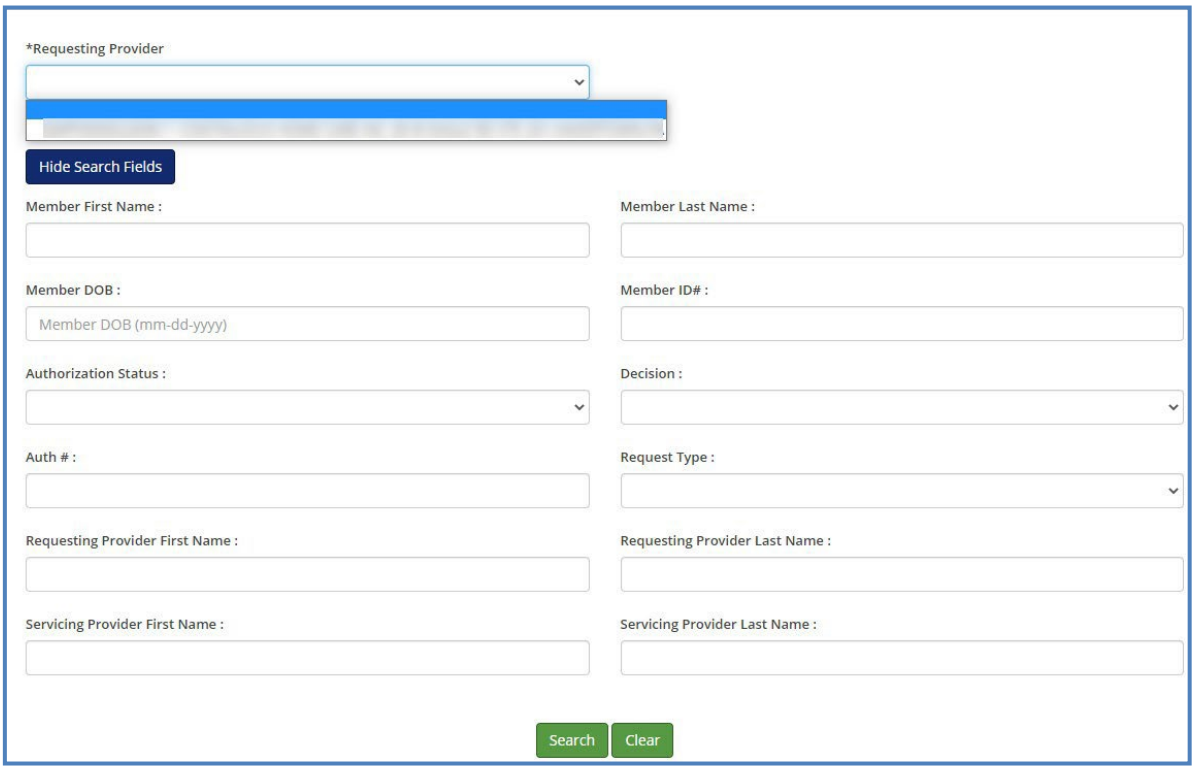
1. Click **Prior Authorization** from the menu options.



2. Click **View Authorizations Medical**.

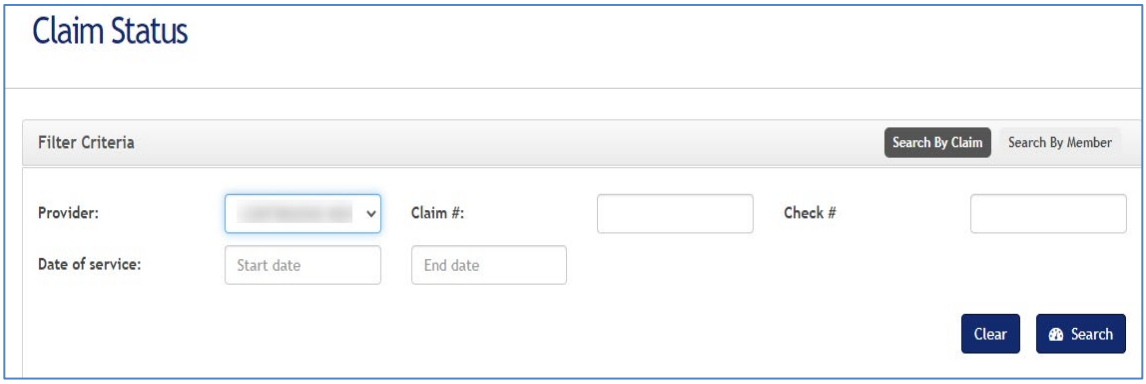
Search for an Authorization

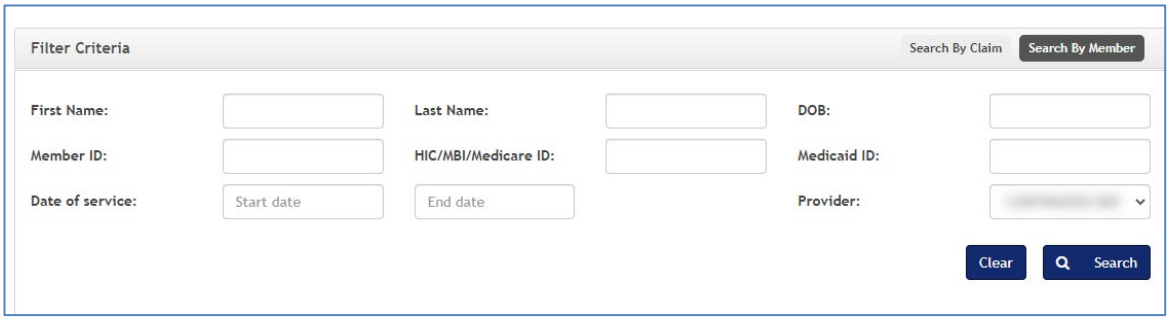
1. Select the appropriate requesting provider from the **Requesting Provider** drop-down menu.
2. Enter the requesting provider first name in the **Requesting Provider First Name** field.
3. Enter any further search criteria. **Note**: You do not need to complete all fields to perform a search.



Search a Claim

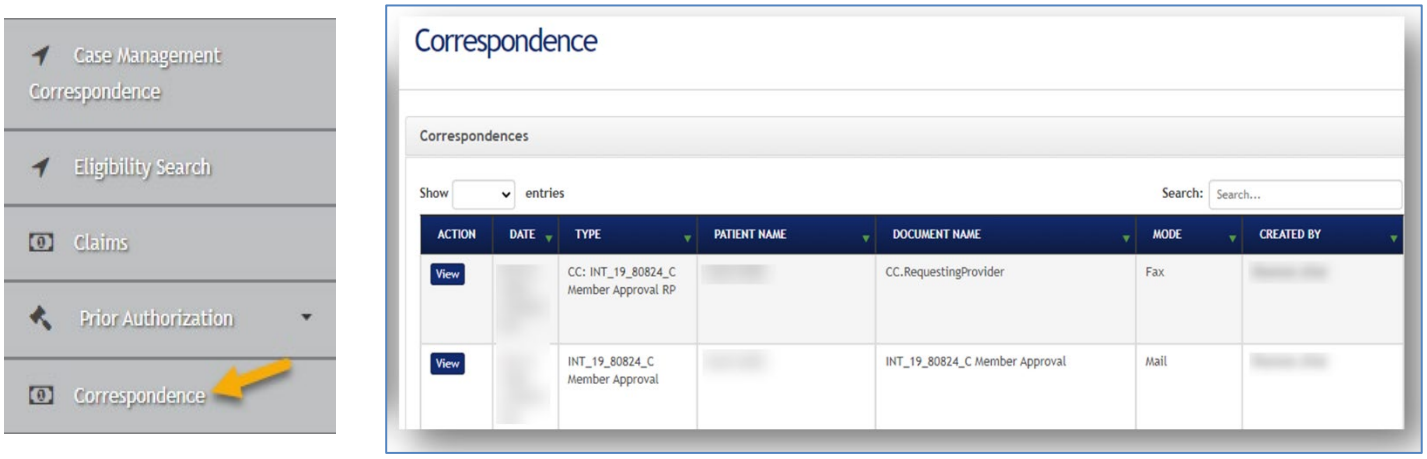
1. Select the appropriate Provider from drop down list. This is the only required.
2. You can choose which field to complete to narrow the search.
3. All fields are not required.





Correspondence Overview

All communications sent to a provider from the health plan are displayed in the Correspondence section.

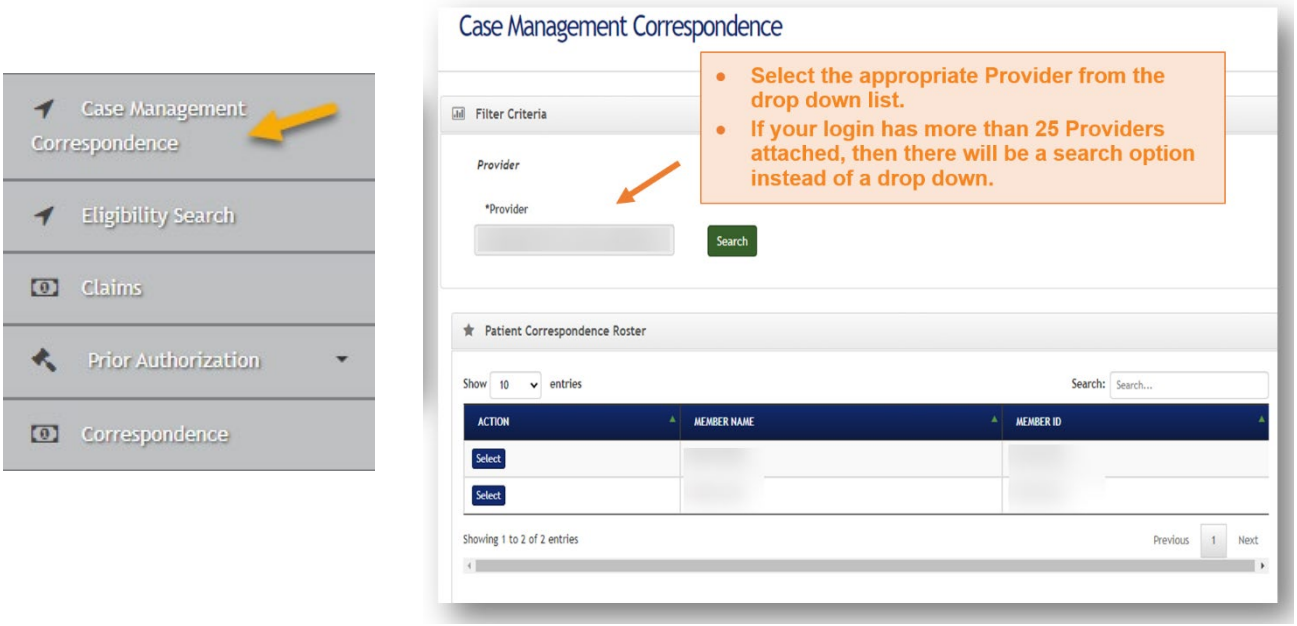


Note: The provider or facility who logs into the MHK Provider Portal can only view the letters that are associated with the Requesting Provider, Servicing Provider, and/or Servicing Facility.

Behavioral Health letters are not displayed due to sensitive diagnosis and test restrictions from a privacy perspective.

Case Management Correspondence

All communications sent to a member from the health plan are displayed in the Case Management Correspondence section and only viewable by the member's PCP.



Frequently asked questions

Background

Q1. What is the HSConnect Portal Enhancement?

Cigna has integrated the industry-leading MHK software platform (formerly MedHOK or Medical House of Knowledge) into its secure Medicare Advantage HSConnect provider portal. This enhancement will greatly simplify and expedite the authorization process for your Cigna Medicare patients. Portal integration will be seamless for providers who have access to HSConnect.

Q2. What does the portal enhancement mean for my practice?

The portal enhancement offers many benefits:

- Get expedited approvals (some at the time of entry)
- Request inpatient and outpatient Medicare service electronically
- Eliminates the need to call or fax to submit information
- Attach all required documentation of any size
- Review the status of requests in real time, 24/7
- Receive a reference number for each request
- Immediate access to decision letters for provider records
- Review claims and payment status

Access and settings

Q1. How do I request access to the MHK portal, HSConnect?

To request access to HSConnect, do the following:

1. Visit HSConnect (https://www.hsconnectonline.com) and click the Need an Account? Click here link. The Request Account screen is displayed.
2. Send an email to HSConnectHelp@HSConnectOnline.com or HSC_Account_Request@HSConnectOnline.com with the following details: Name(s), email address, provider NPI, coverage group name.
3. Contact your local Network Operations Provider Representative.

Q2. How long can my status be idle in HSConnect?

The idle time is 15 minutes. If there is no activity in HSConnect for 15 minutes or more, you will automatically be logged out. Activity is defined as navigating to a new screen in the portal. Typing and selecting drop-down menus is not considered activity.

Note: There is no draft functionality at this time. Prior authorizations must be completed once started before the system times out.

Q3. What browser should I use when accessing HSConnect?

For full functionality, you must use Google Chrome.

Search for a provider's National Provider Identifier (NPI)

Q4. Where can I locate a provider's National Provider Identifier (NPI)?

You can find NPI Numbers for any provider at https://npiregistry.cms.hhs.gov/registry/. Click the submit button once. Please enter demographic information using the appropriate capitalization, as it automatically populates notification letters.

Authorization

Q5. Where can I locate the appropriate authorization and claim dispute forms?

You can locate the appropriate forms on the Cigna Medicare website for providers (MedicareProviders.Cigna.com) under Forms and Practice Support.

Q6. When should I choose the option "expedited authorization urgency"?

An expedited prior authorization request should only be made if you believe that your patient's life, health, or ability to regain maximum function could be seriously harmed by waiting the standard 14 calendar days for a decision.

When submitting a prior authorization in MHK (HSConnect), Expedited Authorization urgency must be selected when the Inpatient or Behavioral Health Inpatient drop-down value is selected from the Request Type field and the Initial Concurrent drop-down value is selected from the Review Type field.

Q7. Is it necessary to enter a service or procedure code for all types of requests?

Yes, when applicable. A service or procedure code is required when submitting an outpatient prior authorization request. In contrast, it is not always necessary or applicable to enter a service or procedure code for an inpatient prior authorization request. The inpatient pre-service request is an exception. For a pre-service request, a service or procedure code needs to be submitted with this prior authorization request.

The Procedure Status field is not populated after the prior authorization has been submitted because a service code (e.g., CPT/HCPCS) was not entered or applicable to the expedited prior authorization request for a behavioral health inpatient admission

Q8. Is it necessary to fill out the Request Admit Date and the Actual Admit Date fields?

Yes, for inpatient requests. The Request Admit Date is the date when the admit date is requested. The Actual Admit Date field should be entered when the member, customer or patient has already been admitted to the inpatient facility. The Actual Admit Due should not be a future date but the actual date that the customer was admitted.

Q9. When should I select YES for Requesting Provider Same as Servicing?

You should select YES when:

- The default NO is used when the Servicing Provider is not the same as the Requesting Provider.
- The YES option is selected when the Requesting Provider and the Servicing Provider are the same.
- HSConnect defaults to NO for the Requesting Provider Same as Servicing Provider field.

Q10. What is the relationship between the Request Type and the Review Type fields?

Selecting a drop-down value in the Request Type field will dynamically display the correspondingdrop-down values in the Review Type field.

Claims

Q11. What is the archived period for claims information?

HSConnect displays 18 months of submitted claims data.

Q12. What criteria is needed to perform a claims search?

Use the following criteria to perform a claims search:

- Search by Claim provides the option to search by provider, claim number, check number, and/or date of service.
- Search by Member provides the option to search by first name, last name, date of birth, member ID, HIC/MBI/Medicare ID, Medicaid ID, date of service, and/or provider.

Letters and correspondence

Q13. Are all letters and correspondence viewable in MHK (HSConnect)?

Yes. A provider or facility who logs into HSConnect can only view the letters that are associated with the Requesting Provider, Servicing Provider, and/or Servicing Facility. Behavioral Health letters are not displayed due to sensitive diagnosis and test restrictions from a privacy perspective.

Q14. Are letters and correspondence available indefinitely or are they archived after a certainamount of time?

Yes. With the exception of sensitive correspondence, all letters and correspondence will be available indefinitely.

Eligibility search

Q15. What information is required to conduct an eligibility search?

- Four elements of protected health information (PHI) are now required to protect member data. These are:
  - Member first name
  - Member last name
  - Date of birth
  - Member ID
    - When hovering of the member ID field, the “Member ID without Special Characters” message will display as a tooltip. This means you should always omit characters when entering any value in the Member ID field. **For example**, use 10000658701 instead of 100006587*01.
- If you are searching for a member by their last name, ensure their full last name includes any suffixes, hyphens, etc.
- If you are unable to locate a member, contact HSConnect Provider Portal Help Desk at 888.952.7596, 7:00 a.m. – 4:30 p.m. CST.

Resources and training

Visit the Cigna Medicare HSConnect web page at https://www.hsconnectonline.com to access the latest training and additional practice support information, including:

- Medicare Advantage Provider Quick Reference Guide
- Coverage Policies

Additional support

- Eligibility/benefits: Provider services for claims, eligibility, benefits, copay, status of claims: Provider Customer Service team Monday–Friday, 8:00 a.m.–5:00 p.m. CST at 800.230.6138.

- Authorization inquiry or status (provider services): For authorization inquiry or status: Provider Customer Service team Monday–Friday, 8:00 a.m.–5:00 p.m. CST at 800.230.6138, select option 3 for Medical Provider, then option 3 for Authorization and Referrals, lastly select option 1 to check the status of an authorization or referral.

- HSConnect Help Desk: For establishing a new account, changing a password, getting answers to questions and other general help, call 866.952.7596, option 2, between Monday–Friday 7:00 a.m.–4:30 p.m. CST or send an email to HSConnectHelp@HSConnectOnline.com.