2023

NONPARTICIPATING PROVIDER MANUAL

MEDICARE ADVANTAGE

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Cigna Medicare Advantage Overview

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

Cigna Medicare Advantage HMO[1] Plans

Customers are required to select a primary care provider (PCP) and receive all covered services by utilizing Cigna Medicare Advantage network-participating providers, except in the case of emergency. Select service areas do not require the use of referrals. See the Referrals and Prior Authorizations section for further information.

HMO plans:

- Cigna Traditions Medicare (HMO I-SNP[2])
- Cigna Total Care (HMO D-SNP[3])
- Cigna Achieve Medicare (HMO C-SNP[4])
- Cigna Preferred Medicare
- Cigna Alliance Medicare

Cigna Medicare Advantage PPO[5] Plans

Generally, customers are encouraged (but not required) to select a PCP and to see Cigna Medicare Advantage-participating providers, including for referrals. However, they may receive out-of-network care and are not limited to their home service area for routine care.

PPO plans:

- Cigna True Choice Plus Medicare
- True Choice
- True Choice Courage
- True Choice Savings
- True Choice Access
- Preferred Savings Medicare

Introduction and New 2023 Plan Offerings

In 2023, Cigna is expanding its Medicare Advantage plans into new markets and offering new products. As a result, nonparticipating providers may start seeing more patients with these plans.

This Nonparticipating Provider Manual is designed to help you and your office staff administer plans for your patients with Cigna Medicare Advantage coverage who may have out-of-network benefits. It is not a binding legal document, but contains important information concerning our policies and procedures, including claims submission requirements and payment, and prior authorization and referral requirements.

Nonparticipating providers should note:

- For select plans, referrals are not required (check your patient's ID card). See the Referrals and Prior Authorizations section for further information.
- For PPO plans:
  - No contract is required to render care. However, you must be eligible for reimbursement under CMS rules and regulations.
  - Reimbursement of covered services will be made in accordance with CMS regulations and the plan's benefits.
- Cigna ID cards provide high-level product and network information, and indicate the customer's plan, referral requirements, and out-of-network benefits. Contact numbers are located on the back of the card for further assistance.

1 Health maintenance organization.
2 Institutional Special Needs Plan.
3 Dual Eligible Special Needs Plan.
4 Chronic Condition Special Needs Plan.
5 Preferred provider organization.

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Key Contacts

Part C Appeals	**Appeals questions:** 800.511.6943 **Mail or fax standard medical appeals to:** Cigna Medicare Advantage Appeals PO Box 188081 Chattanooga, TN 37422 **Fax:** 855.350.8671 **Mail or fax expedited medical appeals to:** Cigna Medicare Advantage Appeals PO Box 188082 Chattanooga, TN 37422 **Fax:** 855.350.8672 **Mail or fax post-service contracted provider appeals to:** Cigna Medicare Advantage Appeals PO Box 188085 Chattanooga, TN 37422 **Fax:** 855.699.8985	
Claims Processing	**Claims questions:** 800.230.6138	
	All providers (except Arizona) **Electronic claims may be submitted through:** • Availity® and Change Healthcare – Payer ID 63092 or 52192 • Capario, Gateway EDI, Office Ally, SSI Group, Vizient, and ZirMed – Payer ID 63092 • Relay Health – Professional claims: CPID 2795 or 3839 Institutional claims: CPID 1556 or 1978 **Mail paper claims to:** Cigna PO Box 981706 El Paso, TX 79998 **Mail reconsideration requests to:** Cigna Reconsiderations PO Box 20002 Nashville, TN 37202	**Arizona providers (HMO only)** **Electronic claims may be submitted to:** Cigna – Payer ID 62308 **Mail paper claims to:** Cigna PO Box 38639 Phoenix, AZ 85069 **Mail reconsideration requests to:** Cigna Reconsiderations PO Box 38639 Phoenix, AZ 85069 **For questions and claim status:** Call Provider Customer Service: 800.627.7534
Provider Customer Service	**All providers (except Arizona)** 800.230.6138	**Arizona providers (HMO only)** 800.627.7534

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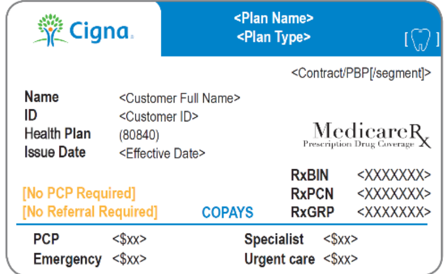
2023 Cigna Medicare Advantage ID Card Examples

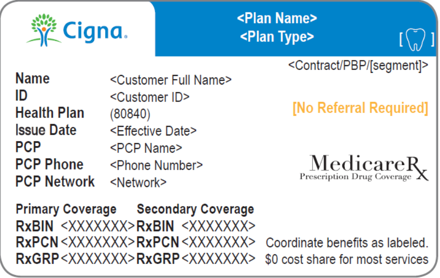
Customer ID cards provide high-level product and network information. Please call the phone numbers on the back of the card for assistance, to verify eligibility, and for guidance regarding referrals and prior authorization requirements.

All states (except Arizona)

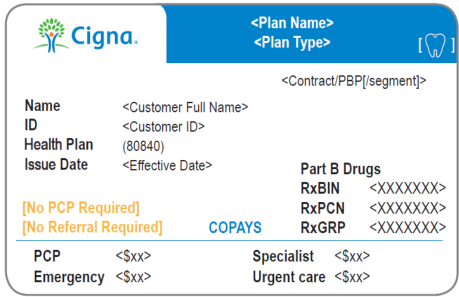
Cigna Medicare Advantage PPO Prescription Drug



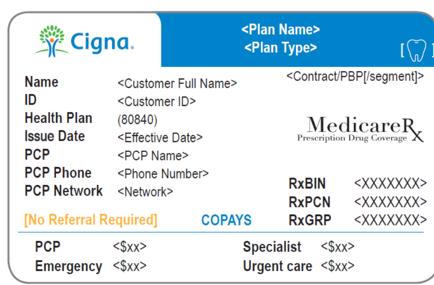
Cigna Medicare Advantage Prescription Drug (Dental Allowance)



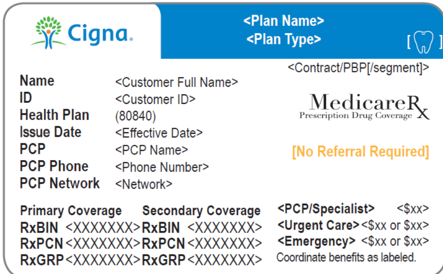
Cigna Medicare Advantage PPO



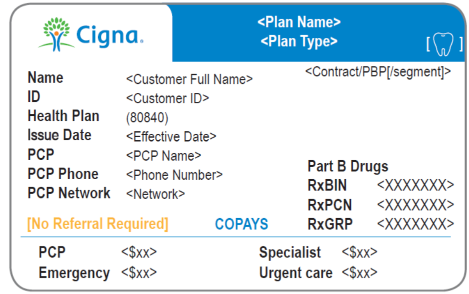
Cigna Medicare Advantage Prescription Drug



Cigna Medicare Advantage Prescription Drug



Cigna Medicare Advantage



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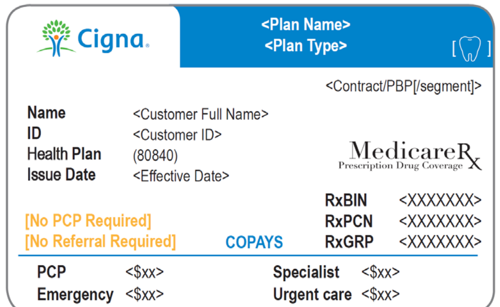
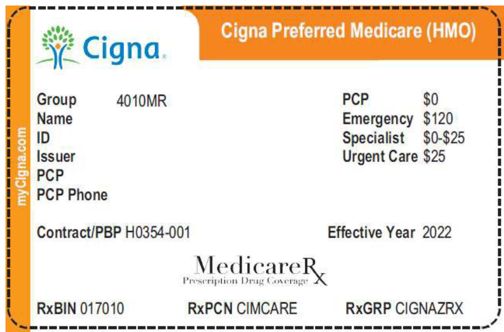
Arizona only

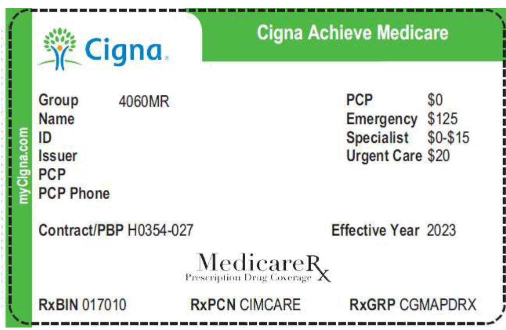
Cigna Medicare Advantage PPO



Cigna Preferred Medicare (HMO)



Cigna Achieve Medicare (HMO C-SNP)



Cigna Alliance Medicare (HMO)

Verify Patient Eligibility and Benefits

To verify your patient's eligibility and benefits:

- **Ask to see the patient's ID card.** It will show their Cigna identification number, plan code, copayment, and effective date. Since changes in eligibility can occur, the card alone does not guarantee the patient is eligible.[6]
- **Call Cigna Medicare Advantage Provider Customer Service at 800.230.6138.** An automated interactive voice response (IVR) system is available 24 hours a day, 365 days a year. You can also speak with a Provider Customer Service Representative Monday–Friday, 8:00 a.m.–5:00 p.m. CST.

Referrals and Prior Authorizations

Referrals and Prior Authorizations at a Glance

Plan	Referrals	Prior Authorizations
HMO	Referrals are only required in Arizona, Colorado, Central and South Florida, Illinois, Oklahoma, and Texas.	**HMO plans require prior authorization for all out-of-network care.** It is also required for any in-network service shown on the Cigna Medicare Advantage Authorization Requirements list.
PPO	Referrals are not required for PPO plans. However, before receiving services from nonparticipating providers, customers may want to ask for a pre-visit coverage determination.	PPO plans require prior authorization for the services included on the Cigna Medicare Advantage Authorization Requirements list. To view the most current list, go to the Cigna Medicare Advantage website (MedicareProviders.Cigna.com) > Prior Authorization Requirements: See Current Requirements [PDF]. Please reference the provider manual for the most current authorization list for the 2022 plans.

6 Customer data is subject to change. CMS retroactively terminates customers for various reasons. When this occurs, Cigna's claims recovery unit will request a refund from the provider. The provider must then contact CMS Eligibility to determine the customer's actual benefit coverage for the date of service in question, typically the customer has moved to another plan.

Quick Reference Referral Guide

The chart below shows all of the regions in which Cigna Medicare Advantage HMO, HMO POS, and PPO plans are offered. Only HMO plans in Arizona, Colorado, Central and South Florida, Illinois, Oklahoma, and Texas require referrals (designed by an asterisk in the chart below). Referral requests may be submitted via fax, phone, or mail.

As a reminder, approval of a referral does not guarantee payment; services must be a covered benefit. To verify benefits before providing services, call ***800.230.6138****.*

Market	HMO	HMO POS	PPO
Alabama			
Arizona			
Arkansas			
Colorado			
Connecticut (New England)	✓		✓
Delaware	✓		✓
Central Florida	✓[7]		✓
North Florida	✓		✓
South Florida	✓[7]		✓
Georgia			
Illinois	✓[7]	✓[7]	✓
Kansas City	✓		
Maryland			
Southern Mississippi	✓		
New Jersey	✓		✓
New Mexico			
North Carolina			
Ohio			
Oklahoma	✓[7]		✓
Oregon (Portland)	✓		✓
Pennsylvania	✓		✓
South Carolina			
St. Louis/Southern Illinois	✓		✓
Tennessee			
Texas	✓[7]		✓
Utah			
Virginia			
Washington	✓		✓
Washington, DC			

7 This plan in this service area requires a referral.

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Requesting Prior Authorization to Nonparticipating Providers

HMO plans

For HMO plans, prior authorization requests are required for ***all*** services before they are rendered by nonparticipating providers. The requests will be reviewed to determine if they meet any of the criteria listed below.

- There is a continuity-of-care issue.
- A network gap has been identified.
- There are 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, or delivery of services is needed at a closer location or sooner than provided or allowed by Cigna's access or availability standards).

It is recommended that a PCP initiate prior authorization requests to nonparticipating providers. However, customers (or their authorized representatives) may make the request on their own behalf.

PPO plans

For PPO plans, Cigna requires prior authorization of certain services, medications, procedures, and/or equipment prior to providing the service. This is to prevent unnecessary utilization while safeguarding the customer's access to the most appropriate medically necessary care. Prior authorization is typically obtained by the ordering provider but it may also be requested by the rendering provider.

To determine if a service or procedure requires prior authorization, view the Cigna Medicare Advantage Prior Authorization Requirements list, which is searchable and updated quarterly. Go to MedicareProviders.Cigna.com > Prior Authorization Requirements: See Current Requirements [PDF]. To search the guide for a code, enter Ctrl + F; then enter the five-digit code.

Additionally, it is recommended (but not required) that you obtain prior authorization for services or procedures to be rendered by nonparticipating providers in the following scenarios:

- There is a continuity-of-care issue.
- A network gap has been identified.
- There are 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, or delivery of services is needed at a closer location or sooner than provided or allowed by Cigna's access or availability standards).
- To confirm that services are covered and medically necessary.

Prior authorization forms

To access our prior authorization forms, go to MedicareProviders.Cigna.com > Find a Form > Prior Authorization Request Forms.

To submit a prior authorization request, visit the HSConnect provider portal at HSConnectOnline.com.

Who is responsible for requesting prior authorization?

Nonparticipating providers are responsible for requesting prior authorization on behalf of their patient, when required, at least 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 patient may also request a determination prior to delivery of services. If this occurs, Cigna or the delegated utilization management agent will contact you for clinical information to support the request.

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If prior authorization cannot be obtained in a timely manner, Cigna or the delegated utilization management agent and the appropriate participating provider must be notified, as applicable, as soon as possible, but no later than 24 hours after providing or ordering the covered services, or on the next working day.

Prior authorization of home health services

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

A Medical Director reviews all home health services that do not meet medical necessity criteria and issues a determination. If the Medical Director deems that the services are not medically necessary, they will issue an adverse determination (a denial). The Prior Authorization Nurse or designee will notify the provider and customer verbally and in writing of the adverse determination via notice of denial.

Notice of Medicare Non-Coverage (NOMNC)

Cigna or the delegated utilization management agent will issue a Notice of Medicare Non-Coverage (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 NOMNC provided by Cigna in accordance with CMS guidelines. The home health provider is responsible for delivering the notice to the customer, their authorized representative, or the person to whom they have granted power of attorney (the "attorney-in-fact.") at least two calendar days prior to the end date of the currently approved prior authorization, or the second to last day of service if care is not being provided daily.

For services less than two calendar days in duration, the provider is responsible for issuing 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 that the customer, authorized representative, or attorney-in-fact signs the notice within the specified time frame. The NOMNC includes information on a 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 or the delegated utilization management agent 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 care during observation, inpatient (acute, long-term acute care, rehabilitation), and skilled nursing facility admissions in order to ensure:

- Reasonable and necessary covered services or supplies are being provided at the appropriate level of care by a physician, hospital, or other health care provider licensed by the appropriate state or federal agency, or as otherwise approved by Cigna.
- Services are not experimental or investigational, and are consistent with the symptoms or diagnosis of the customer's condition, disease, ailment, or injury.
- Services are not primarily for the personal comfort or convenience of the customer or their family, physician, hospital, or other health care provider.
- Services are the most appropriate supply or level that can safely be provided to the customer consistent with standards of good medical practice.
- Services are being administered according to the individual facility contract.

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All requests for admission, including observation and inpatient level of care, are subject to medical necessity review. The fact that a provider has prescribed, performed, ordered, or coordinated a service or course of treatment does not, in and of itself, mean it is medically necessary. In making determinations as to whether a particular covered service is medically necessary, Cigna shall consider the terms of the customer's benefit plan, national and local medical coverage guidelines (as applicable), scientifically based clinical criteria, treatment guidelines, and decision-making tools, as well as the customer's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. No service is a covered service unless it is medically necessary.

Observation level of care is an alternative to an inpatient admission that allows reasonable and necessary time to render medically necessary services and evaluate the customer's response to services before a decision to admit or discharge can be made. Observation level of care is not expected to exceed 24 hours, but may extend to 48 hours. Discharge or admission must occur less than 48 hours after the customer is admitted to observation status. There will be no reimbursement for observation services in excess of 48 hours. A request for level-of-care change to the inpatient setting will be reviewed, if requested, and a determination will be made according to medical necessity.

Admission Notifications

Cigna requires admission notification for the following:

- Elective admissions
- ER and urgent observation, and acute admissions
- Observation and acute admissions following outpatient procedures

Emergency or urgent admission notification must be received via fax or phone within 24 hours of admission or the 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 providers and discharge planners.

Failure to comply with notification timelines or to provide timely clinical documentation supporting the admission or continued stay could result in an adverse determination.

Cigna's preferred method for concurrent review is electronic medical record access. Concurrent review documentation can also be received via fax. Live dialogue between our concurrent review nursing staff and the facility's utilization management staff is encouraged to assist with discharge planning and needs. Admission notification and clinical information should be received within 24 hours of admission or observation status. If clinical information is not received within 72 hours of admission or the last covered day, the case will be reviewed for medical necessity with the information Cigna has available.

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Billing and ERA/EFT

Claims Submission (all states except Arizona)

Cigna prefers electronic submission of claims. However, both electronic and paper claims are accepted. *Please refer to the Key Contacts chart for information about Part C appeals, reconsideration requests, and claims questions.*

Electronic Claims Submission

Claims may be submitted electronically through the vendors listed below.

Vendor name			Payer ID
• Availity	• Change Healthcare		62308 or 52192
• Gateway EDI • MedAssets	• Office Ally • ProxyMed	• SSI Group • ZirMed	63092

Paper Claims Submission

Please mail claims to the following address:

Cigna Claims
PO Box 981706
El Paso, TX 79998

Supporting documentation

Please send supporting claims documents (e.g., medical records, itemized bills, explanation of benefits [EOB]) via fax at **615.401.4642** or mail them to:

Cigna Claims Intake
PO Box 20002
Nashville, TN 37228

ERA and EFT (all states except Arizona)

ERA and EFT enrollment

You may enroll in electronic remittance advice (ERA) and electronic funds transfer (EFT) on the Change Healthcare website (ChangeHealthcare.com). To access the ERA and EFT enrollment forms, go to ChangeHealthcare.com > Support > Enrollment Services.

- **To receive ERA files**, select ERA Enrollment Forms.
  - In Section ERA Payer Enrollment Forms, select institutional or professional; enter 52192 in the search bar; click enter.
  - Click on the Cigna form and complete it.
  - Send the completed form to Change Healthcare using the email address shown at the bottom of the form.

- **To receive EFT payments**, select EFT Enrollment Forms.
  - To set up a new EFT, change an existing EFT banking, or change an existing EFT payer, select the EPayment Request Forms.
  - Complete the form.
  - Email the completed form to EFTEnrollment@ChangeHealthcare.com or fax it to **615.238.9615**.

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- **To change a contact on an existing EFT**, select EFT Enrollment Forms > Epayment Contact Change Form.
  - Complete the form.
  - Email the completed form to EFTEnrollment@ChangeHealthcare.com or fax it to **615.238.9615**.

ERA and EFT post-enrollment support

After enrolling in ERA and EFT, please call the appropriate phone number below if you need assistance.

- EFT: **866.506.2830**, option 2
- ERA and claims: **866.742.4355**, option 1

Providers enrolled in EFT can also view electronic payments and remittances via the Change Healthcare Claims & Denials Advisor portal at https://CDA.ChangeHealthcare.com/Portal.

- To request a user name and password, call **866.506.2830**.
- To access the user guide for the Change Healthcare Claims & Denials Advisor portal, log in to https://CDA.ChangeHealthcare.com/Portal.
- If you are not enrolled in EFT or are only set up for ERA, you may call Change Healthcare at **866.369.8805** to request a paid version of the Change Healthcare Claims & Denials Advisor portal.
- Alternatively, providers that are not enrolled in EFT may request access to the Vision Tool by logging in to the Change Healthcare | ON24/7 website and submitting a request to view claims and ERAs.
- For additional support, download the Change Healthcare Provider Quick Reference User Guide from the Change Healthcare website (ChangeHealthcare.com > Support: Enrollment Services > Provider Quick Reference User Guide).

Claims Submission (Arizona only)

Cigna prefers electronic submission of claims. However, electronic and paper claims are accepted. *Please refer to the Key Contacts chart for information about Part C appeals, reconsideration requests, and claims questions.*

Electronic Claims Submission

If you are interested in submitting claims electronically via electronic data interchange (EDI), contact Cigna Provider Customer Service for assistance at **800.627.7534**.

Electronic claims may be submitted through payer ID 62308.

Paper Claims Submission

Please mail claims to the appropriate address shown below.

PPO only:	**HMO only:**
Cigna PO Box 981706 El Paso, TX 79998	Cigna PO Box 38639 Phoenix, AZ 85069

Supporting documentation

Please send supporting claims documents (e.g., medical records, itemized bills, and EOBs) with the original paper or EDI submission. At the request of Cigna, you may also fax them to **602.792.6332** or mail them to the address above.

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ERA and EFT (Arizona only)

EFT

- If you want to designate a savings account for EFT deposits, verify that your bank supports this before you begin the enrollment process.
- The enrollment process typically takes two to six weeks.
- When you enroll in EFT with Cigna, you can choose to have your payments grouped or bulked in one of two ways:
  - Based on your Taxpayer Identification Number (TIN) and payment address, or
  - By your billing provider's National Provider Identifier (NPI) from your submitted claims.
- If your TIN, billing address, or bank account changes, you must submit a change request by logging in to the Cigna for Health Care Professionals website (CignaforHCP.com) > Working with Cigna > Manage EFT Settings.
- If a remittance report for a customer with a Cigna Choice Fund® reimbursement account (health reimbursement account [HRA], health savings account [HSA], or flexible spending account [FSA]) is not included with the Cigna medical payment, it will be mailed to you within 48 hours.

EFT enrollment process

There are two ways you can enroll in EFT:

- **CAQH website.** Enroll in EFT with multiple payers, including Cigna, using the Council for Affordable Quality Health Care (CAQH) website.
- **CignaforHCP.com.** Enroll in EFT directly with Cigna:
  - Log in to CignaforHCP.com > Working with Cigna > Enroll in Electronic Funds Transfer (EFT) Options.
  - Cigna will send a "prenote" transaction to your bank to verify all the banking information is correct.
    - If the prenote is not returned to Cigna, you will begin receiving EFT payments on your next payment cycle.
    - If the prenote is returned with errors, Cigna will contact you to obtain the correct banking information.
  - To check the status of your EFT application, log in to CignaforHCP.com > Working with Cigna > Manage EFT Settings. *If you are not registered for CignaforHCP.com, go to CignaforHCP.com and click Register.*

ERA enrollment

To enroll in ERA with Cigna, contact your EDI vendor.

Online remittance reports

Access your Cigna remittance reports online the same day you receive your electronic deposit. Learn more about EFT and online remittance reports by going to CignaforHCP.com > Get questions answered: Resource > Medical Education and Training or call **800.88Cigna (882.4462)**.

Claims Review

Cigna's review of claims may result in payments being classified as overpayments. The review includes, but is not limited to, itemized bills, clinical records, or notes (collectively "Records"). *Unless agreed upon otherwise with Cigna, the provider shall have 60 days to produce the requested Records. Failure to produce Records within the required time frame may result in services being deemed unsupported and other adverse findings, and corresponding repayment demands. In the event that an inspection, evaluation, or audit of Records leads to adverse findings, Cigna shall have the right to deny future claims submitted by the provider. The provider shall have the right to appeal any such denial on a claim-by-claim basis.*

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Timely Filing

According to Medicare standards, claims from nonparticipating providers are to be submitted within 365 days from the date of service. Claims received after 365 days will be denied for timely filing.

Florida Custodial Care Claims

Providers must request prior authorization when a patient requires admission to a nursing facility. Notification to the health plan must be provided within 24 hours of knowledge of hospitalization. Nonparticipating providers must submit claims within 365 days after discharge.

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. 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. The provider's staff must download any files placed for receipt within 24 hours, as all data is deleted on a fixed schedule. If the files cannot be downloaded, alternative arrangements for retransmission must be made. The provider and their staff will work collaboratively with Cigna to ensure information is adequately protected and secure during transmission.

Reimbursement of Nonparticipating Providers

PPO plans

Cigna Medicare Advantage PPO plans follow CMS rules and regulations for reimbursement of nonparticipating providers for covered services rendered to our customers.

Depending on your Medicare-participation status, you will be paid as followed for covered plan services:

- If you are not contracted with Cigna Medicare Advantage, but are a Medicare-participating provider (you **always** accept assignment), then you will be reimbursed the Medicare allowed amount minus any applicable patient cost share. Per CMS requirements, you must accept Cigna's payment and any associated cost share as payment in full. Under a Cigna Medicare Advantage PPO plan, you may **only** bill patients for their cost-share amounts and for any noncovered services. You may not balance bill patients or Cigna for covered services in excess of the original Medicare rate.

- If you are not contracted with Cigna Medicare Advantage and are not a Medicare-participating provider (you accept assignment on a **case-by-case basis**), you will be reimbursed as follows:

    - If **you accepted assignment** for the services and affirmatively indicated acceptance on the submitted claim, you will be reimbursed the Medicare allowed amount minus any applicable patient cost share. You must accept Cigna's payment and any associated cost share as payment in full. Under a Cigna Medicare Advantage PPO plan, you may bill patients for their cost-share amounts, and for any noncovered services. You may not balance bill patients or Cigna for covered plan services in excess of the original Medicare rate.

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- If **you did not accept assignment** for the services, you will be reimbursed up to the original Medicare limiting charge minus any applicable patient cost-share amount. Under a Cigna Medicare Advantage PPO plan, you may bill patients for their cost-share amounts and for any noncovered services. You may not balance bill patients for covered plan services in excess of the plan cost share. Cigna is responsible for paying you the difference between a patient's cost share and the original Medicare limiting charge.

HMO plans

Cigna Medicare Advantage HMO plans do not have out-of-network benefits. However, if any of the following apply, you can submit a prior authorization request. If approved, Cigna will reimburse the provider at the Medicare reimbursement rate.

- There is a continuity-of-care issue.
- A network gap has been identified.
- There are 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, or delivery of services is needed at a closer location or sooner than provided or allowed by Cigna's access or availability standards).

CMS Preclusion List

CMS publishes a Preclusion List of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs.

Why is this important?

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

- Medicare Advantage plans must deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.
- 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.

Who is on the list?

Individuals or entities will be on the Preclusion list when they:

- 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. In advance of their inclusion on the Preclusion List, CMS sends an email and letter to providers using the Provider Enrollment Chain and Ownership System (PECOS) address or National Plan and Provider Enumeration System (NPPES) mailing address. The communications include the reason for the preclusion, its effective date, and the applicable rights to appeal. View the Preclusion List.

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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 nonparticipating providers to be aware of these vendor-specific networks to avoid potential claims issues and customer confusion.

Cigna currently utilizes the following three vendor-specific networks:

- Hearing Care Solutions (for routine hearing-related benefits and supplies)
- EyeMed (for routine vision services and supplies)
- American Specialty Health® (ASH) (for chronic lower back pain acupuncture services)

In Cigna Medicare Advantage **HMO** plans, hearing, vision, and acupuncture services may be covered only when they are supplied by providers that participate in the Hearing Care Solutions, EyeMed, or ASH networks.

In our **PPO** plans, they may be covered at the in-network benefit and cost-sharing levels only when they are supplied by providers that participate in the Hearing Care Solutions, EyeMed, or ASH 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 any of these vendor-specific networks before providing related services. To explore participating in these networks, please contact your Network Operations Representative or visit the vendors' respective websites:

- Hearing Care Solutions: HearingCareSolutions.com
- EyeMed: EyeMed.com
- American Specialty Health: ASHLink.com > Join Our Network: Providers

Join the Cigna Medicare Advantage Network

To join the Cigna Medicare Advantage network, visit MedicareProviders.Cigna.com > Find a Form, and complete the applicable form(s) specific to a market:

- Network Interest Forms – Facility/Ancillary, or
- Network Interest Forms – Practitioner

All applicants must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. Every provider undergoes a rigorous verification process that includes primary and secondary source verifications of all applicable information for the contracted specialty(s).

Cigna does not discriminate – in terms of participation or reimbursement, or based on the population of customers serviced – against any health care provider who is acting within the scope of his or her license or certification under state law.

Provider notification

All initial applicants who successfully complete the credentialing process are notified in writing of their network effective date. Providers can accept Cigna Medicare Advantage PPO plan customers and bill Cigna. A prior authorization request is recommended to confirm that services are covered and are medically necessary, but not required.

Applicants who are denied participation in the Cigna Medicare Advantage network will be notified in writing within 60 days of the decision, along with details regarding the reason(s) for the denial.

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Appendix

If You Can Accept Medicare Advantage, You Can Accept These Plans flyer

IF YOU ACCEPT MEDICARE ADVANTAGE, YOU CAN ACCEPT THESE PLANS.

Cigna Medicare Advantage Preferred Provider Organization (PPO) guide for nonparticipating providers.

Did you know?

Cigna Medicare Advantage Preferred Provider Organization (PPO) plan customers can go to any participating or nonparticipating Medicare provider without a referral. That means you can:

- Accept patients with these ID cards; look for "PPO" plan type in blue section of the card
- Collect copayment or coinsurance at time of service, depending on the patient's plan
- Submit claims to Cigna for covered services and receive one payment; see **MedicareProviders.Cigna.com > Nonparticipating Provider Manual** for further information.

Claims processing

- **ELECTRONIC CLAIMS SUBMISSION:**
  - Change Healthcare/Availity (Payor ID: 63092 or 52192)
  - SSI Group/MedAdvent/MedAssets /ZirMed/ Office Ally/Gateway EDI (Payor ID: 63092)
  - Relay Health (Professional claims CPID: 2795 or 3839, Institutional claims CPID: 1556 or 1978)
- **PAPER CLAIMS SUBMISSION:**
  - Cigna Medicare Advantage P.O. Box 981706, El Paso, TX 79998

Contact information

- To verify eligibility and benefits, or obtain prior authorization for Cigna Medicare Advantage patients, call **800.230.6138** Monday - Friday, 8:00 a.m. - 5:00 p.m. CT.
- To view our *Nonparticipating Provider Manual*, visit **MedicareProviders.Cigna.com > Nonparticipating Provider Manual**.
- **Join our growing Medicare Advantage network.** To learn more, see the reverse side of this flyer.

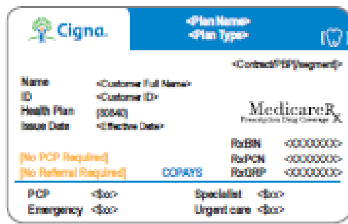
Important information

- **PRIOR AUTHORIZATION**
  Prior authorization is only required for in-network and out-of-network services listed at **MedicareProviders.Cigna.com > Prior Authorization.**

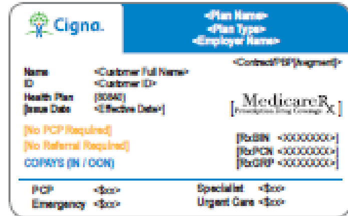
  This allows us to confirm that these services are covered and are medically necessary for:
  - Inpatient hospital and skilled nursing admissions*
  - Outpatient procedures, services, and supplies
- **Patients with coverage through employer groups pay the same out of pocket for in-network and out-of-network covered services.**

Sample ID cards

Individual



Employer group



* Prior authorization allows us to inform you about our patient support programs that may help your patients.

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Helping Patients, Together flyer

HELPING PATIENTS, TOGETHER

Join our growing network of Cigna Medicare Advantage participating providers.

For more than 125 years, Cigna has been committed to building a trusted network of health care providers to connect our customers with truly personal care. As a Cigna Medicare Advantage contracted provider, you join a global network of more than 1.5 million health care providers, clinics, and facilities.

Capitalize on a growing patient base

- 61 percent of Medicare beneficiaries will be in an Medicare Advantage plan by 2032.*
- Cigna is expanding its Medicare Advantage geographic footprint by 22 percent in 2023.

We understand your market, your business, and its challenges

If you have a need or a question about how we can work together better, our local Medical Market Executives, Network Operations, and Provider Customer Service teams are always available to assist you.

Competitive compensation

Participating health care providers are compensated competitively for their services.

Opportunity to earn quality incentives

Our Partnership for Quality (P4Q) program helps providers close gaps in care so they earn incentives based upon national performance measures.

Clinical collaboration and enhanced benefits to support patients' unique needs

- Free consultative resources and targeted data offers a comprehensive snapshot of your patient's health.
- The majority of Cigna Medicare Advantage 2023 plans include hearing, vision, dental, and fitness benefits, $0 copayments for primary care when visiting participating providers, meal delivery service following a hospital discharge, and coverage of some over-the-counter health-related products. In addition, most customers also have a transportation benefit, which provides rides to and from health-related facilities.

Referrals not required

Most of our Preferred Provider Organization/Health Maintenance Organization (PPO/HMO) plans do not require referrals, which saves your practice time and helps your patients get additional care quickly.

24/7 Practice support information is always available at MedicareProviders.Cigna.com.

Learn more about joining the Cigna Medicare Advantage network

– Visit MedicareProviders.Cigna.com > **Find a Form** > Network Interest Forms-Practitioner, and click on your market of interest.

– After submission, we will reach out to you.

*Meredith Freed. "Medicare Advantage I 2022: Enrollment Update and key trends." Kaiser Family Foundation. 25 August 2022. Retrieved from https://www.KFF.org/medicare/issue-briedd/medicare-advantage-in-2022-enrollment-update-and-key-trends/.

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