2023

PARTICIPATING PROVIDER MANUAL

MEDICARE ADVANTAGE

cigna healthcare℠

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Introduction

Thank you for participating in the Cigna Medicare Advantage network. This provider manual has been created to help you and your office staff administer plans for your patients with Cigna Medicare Advantage plan coverage. It contains important information about our policies and procedures, including claims payments and submission requirements, and prior authorization and referral requirements. Please make time to review the manual carefully.

Note that this manual serves as an extension of your network-participation agreement, which all providers are required to comply with. It replaces and supersedes all 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.

Cigna Medicare Advantage Plans Overview

This manual will guide you through the differences between our health maintenance organization (HMO) and preferred provider organization (PPO) plans.

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

Topic	What you need to know
Referrals	• **HMO:** Referrals required in select plans. See the Referral Quick Reference Guide section to determine what markets require referrals. • **PPO:** Referrals not required. However, before receiving services from providers that do not participate in the Cigna Medicare Advantage network, the customer may want to ask for a pre-visit coverage determination.
Local network information	• Regional service-area maps are located in the Appendix. • Market-specific contacts are located throughout this manual depending on the topic. • See the 2023 Customer ID Cards section provide high-level product and network information. Refer to the phone numbers on the ID card for assistance, and follow guidance for eligibility verification, referrals, and prior authorizations.

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.

Plan type	Selection of a primary care provider (PCP)	Referrals to specialists	Cigna ID card
HMO	Customers are: • Required to select a PCP. • Allowed to select a different PCP at any time.	Not required, although encouraged to select a PCP.	The customer's plan type will be indicated at the top of their Cigna ID card. See the 2023 Cigna Medicare Advantage Customer ID Cards section.
PPO	• Referral requirements are indicated on the customer's Cigna ID card (except in Arizona). • Select service areas do not require the use of referrals.	Not required.	

Key Contacts

Below is a list of frequently used key contacts. For additional key contacts, see the applicable guide below.

- Cigna Medicare Advantage Provider Quick Reference Guide
- Cigna Medicare Advantage Provider Quick Reference Guide (Arizona only).

Behavioral health and substance use disorders	***Note:*** *Please call for prior authorizations.* Phone: 866.780.8546 Fax: 866.949.4846	
Compliance	Report potential fraud, waste, or abuse to the Cigna Special Investigations Unit. **Mail:** Cigna Attn: Special Investigations Unit PO Box 20002 Nashville, TN 37228	**Email or phone:** Cigna Medicare Advantage Operations Email: SpecialInvestigations@Cigna.com Phone: 800.667.7145
Credentialing	Council for Affordable Quality Healthcare (CAQH®) Website: Proview.CAQH.org	
Claims processing	**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 **Claims questions:** Phone: 800.230.6138	**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 **Claims questions:** Phone: 800.627.7534
Coding and documentation	Coding and documentation resources are located on the Cigna Medicare Advantage Providers website (MedicareProviders.Cigna.com) > Provider Education > Documentation and Coding Resources.	
Eligibility verification and copayment information	**All providers (except Arizona)** Phone: 800.668.3813 Website: HSConnectOnline.com	**Arizona providers (HMO only):** Phone: 800.627.7534 Website: ClaimStatMCIS.com **Arizona providers (PPO only):** Phone: 800.668.3813

<table>
<tr><td>Utilization management: eviCore healthcare®</td><td colspan="2">For additional information on submitting prior authorization requests to eviCore go to MedicareProviders.Cigna.com > Provider Quick Reference Guide.</td></tr>
<tr><td rowspan="3">Dental benefits</td><td>Supplemental benefits questions
Phone: 800.230.6138.

Dental allowance questions
Phone: 866.213.7295</td><td>Claims mailing address:
Cigna Dental
PO Box 188037
Chattanooga, TN 37422-8037</td></tr>
<tr><td colspan="2">DHMO plans:</td></tr>
<tr><td>All providers (except Arizona)
Phone: 866.213.7295.</td><td>Arizona providers only:
Phone: 800.367.7037</td></tr>
<tr><td>Provider portal: HSConnect (excludes Arizona providers)</td><td colspan="2">Enter referrals, inquire about referrals and inpatient prior authorizations, verify eligibility, and review claim payments.
Phone: 866.952.7596, Option 2
Email: HSConnectHelp@HSConnectOnline.com|
Register for HSConnect: HSConnectOnline.com/login.aspx</td></tr>
<tr><td>Outpatient laboratory services</td><td colspan="2">For a complete list of participating outpatient laboratories, go to Cigna.com > Find a Doctor > Medicare.</td></tr>
<tr><td>Part C appeals</td><td>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</td><td>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 network-participating provider appeals to:
Cigna Medicare Advantage Appeals
PO Box 188085
Chattanooga, TN 37422
Fax: 855.699.8985</td></tr>
<tr><td>Pharmacy Part B</td><td colspan="2">Pharmacy prior authorization requests can be submitted several different ways:
• Electronic: CoverMyMeds® website (CoverMyMeds.com) (preferred method)
• Forms: Cigna.com/Medicare/resources/drug-search
• Phone: 877.813.5595
• Fax: 866.845.7267

Drug formulary:
Cigna.com/Medicare/part-D/drug-list-formulary</td></tr>
<tr><td>Prior authorization (excludes pharmacy)</td><td>Services requiring prior authorization:
• Inpatient and elective admission notifications
• Outpatient services

To view a complete list of codes that require prior authorization:
Go to MedicareProviders.Cigna.com > Prior Authorization Requirements.

To search the document for a specific code, enter Ctrl+F and enter the five-digit code.</td><td>To find prior authorization forms:
Go to MedicareProviders.Cigna.com > Claims, Appeals, Forms, and Practice Support > Prior Authorization Request Forms.

To submit a prior authorization request (except Arizona):
Visit the HSConnect Provider portal.</td></tr>
</table>

Provider Customer Service	**All providers (except Arizona)** Phone: 800.230.6138	**Arizona providers (HMO only)** Phone: 800.627.7534
Supplemental benefits	Phone: 800.230.6138.	

Customer Eligibility Verification

All participating providers are responsible for verifying a customer's eligibility for each visit. You must call Cigna to verify eligibility when the customer cannot present identification or does not appear on your monthly eligibility list.

Please note that while Cigna will have the most up-to-date information available, customer data is subject to change; CMS can retroactively terminate customers for various reasons that can retroactively affect their eligibility. If Cigna pays a claim that is then retroactively terminated, our 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.

The table below outlines methods to verify customer eligibility.

Method	Contact/resource information
Cigna Medicare Advantage Provider Customer Service	Phone: 800.230.6138, Monday–Friday, 8:00 a.m.–5:00 p.m. CT Phone: 800.627.7534 (AZ HMO only)
HSConnect *Excludes Arizona providers*	Portal: HSConnectOnline.com
Claimstat Managed Care Information System *Arizona providers, HMO only*	Portal: ClaimStatMCIS.com
Customer's Cigna ID Card	Review the customer's Cigna ID card to determine the following: • Plan code *(excludes Arizona)* • Name of PCP (HMO only) • Copayment • Effective date See the Appendix: 2023 Cigna Customer ID Cards.

Claim Submission and ERA/EFT

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.* If you are interested in submitting claims electronically via electronic data interchange (EDI), call Cigna Medicare Advantage Provider Customer Service at **800.230.6138**.

Claims Submission (all states except Arizona)

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 claim documentation

Please send supporting claims documents (e.g., medical records, itemized bills, explanation of benefits [EOBs]) via fax to **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**.
- **To change a contact on an existing EFT**, select Medical and Hospital: EFT Enrollment Forms > New Provider/Existing Providers: Payment Manager Admin 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 username and password, call **866.506.2830**.
- To access the user guide for the Change Healthcare Claims & Denials Advisor portal, log in tohttps://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.
- Alternately, 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, 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

If you are interested in submitting claims electronically via EDI, call 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:
Cigna
PO Box 981706
El Paso, TX 79998

HMO only:
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.

ERA and EFT (Arizona only)

EFT enrollment

- 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 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 yet registered for the website, 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 repots 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)**.

Florida Custodial Care Claims

Florida providers must request prior authorization when a Dual Eligible Special Needs Plan (D-SNP) customer requires admission to a nursing facility.

Claims submission

Claims can be submitted electronically or by mail within 180 days from the initial date of service. Providers will need to follow their contract or provider manual time frames.

Timely Filing

As a Cigna network-participating provider, you have agreed to submit all claims within the time frames outlined in your provider agreement.

Claim Format

The standard CMS-required forms and data elements can be found in the CMS claims processing manual located on the CMS website (CMS.gov) > Regulations & Guidance > Manuals > Internet-Only Manuals (IOMs) > 100-04 > Chapter 12 – Physicians/Nonphysician Practitioners (PDF). Appropriate forms and data elements must be present for a claim to be considered a clean claim.

Cigna can only pay claims that 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 and 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 that is representative of the combined visits and submit the appropriate code for that level.

Physicians who are in the same group practice, but in different specialties, may bill and be paid separately if they perform a service on the same day to the same to the same customer in the same group.

Claim format standards

Cigna pays clean claims according to contractual requirements and 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.

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”). If requested by Cigna or our designee, providers must submit requested records within 30 days for Cigna to accurately adjudicate all claims in a timely manner.

Offsetting

Providers that participate in the Cigna network will be informed of any overpayments or other payments owed to us. They will have 30 days from receipt of the repayment request to refund the amount owed. We will provide:

- The patient's name
- Identification number
- Cigna's claim number
- Your customer account number
- Date of service
- A brief explanation of the recovery request
- The amount owed

If we do not receive the requested amount owed within 30 days, we will offset the amounts identified in the initial repayment request or in accordance with the terms of your agreement, unless we receive an appeal. In addition, any CMS fee schedule or pricing changes will be applied and effective on the date specified by CMS. Evidence of such adjustments shall be included in the explanation of payment (EOP) or remittance advice.

Claims Encounter Data

Providers who are paid under capitation agreements must submit claims to capture encounter data as required according to their Cigna Provider Agreement.

EOP and Remittance Advice

An EOP and remittance advice are sent to providers 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.

Nonpayment and Claim Denial

Any denials of coverage or nonpayment for services by Cigna will be addressed on the EOP or remittance advice. An adjustment or denial code will be listed for each billed line, if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP and remittance advice.

In accordance with your contract, you may not bill the customer for covered services denied by Cigna. In some instances, providing the needed information may reverse the denial (e.g., referral form with a copy of the EOP and remittance advice, authorization number). When no benefits are available for the customer or the services are not covered, the EOP and remittance advice will alert you to this, and in some circumstances you may bill the customer.

Pricing

Overview

Original Medicare typically has market-adjusted prices by code – such as by Current Procedural Terminology (CPT®) code or Healthcare Common Procedure Coding System (HCPCS) code – for services that Original Medicare covers. However, there are occasions where Cigna offers a covered benefit for which Medicare has no pricing. 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 payers, fiscal intermediaries, or state-published schedules for Medicaid.

We request 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 the right to submit a claim dispute or reconsideration request if you feel the reimbursement was incorrect. In the instance of an inpatient admission downgrade to observation, please submit an itemized bill that includes CPT and/or HCPCS codes to expedite processing.

Pricing of inpatient claims

Unless your 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 their inpatient hospital admission, regardless of the number of uninterrupted days prior to the inpatient admission, will be paid under the applicable inpatient Medicare Severity Diagnosis Related Group (MS-DRG).

Skilled nursing facility consolidated billing

Cigna pays for the majority of services provided to customers in a Medicare-covered Part A skilled nursing facility (SNF) stay — including most services provided by entities other than the SNF — 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 and provided by entities other than the SNF, the entities will look to the SNF for payment and must not bill separately for those services.

Consolidated billing resources

For more information, take the SNF Consolidated Billing training on the Medicare Learning Network® Learning Management and Product Ordering System. Go to CMS.gov > Outreach & Education > Medicare program > Medicare Learning Network (MLN) Homepage > Training: Web-Based Training > SNF Consolidated Billing. To help determine how consolidated billing applies to specific services, refer to the flowcharts in the Skilled Nursing Facility Prospective Payment System processing of hospice claims. Go to CMS.gov > Medicare > Medicare Fee-for-Service Payment: Skilled Nursing Facility PPS.

Hospice claims

A Medicare Advantage enrollee who elects hospice care, but chooses not to disenroll from the plan, is entitled to continue to receive through the plan any Medicare Advantage benefits other than those that are the responsibility of the hospice. Under such circumstances, the Medicare Advantage plan is paid a reduced capitation rate for that enrollee by CMS and the Medicare Advantage plan is responsible for continued coverage of supplemental benefits. CMS pays: (a) the hospice program for hospice care furnished to the enrollee and (b) the Medicare Advantage plan, providers, and suppliers for other Medicare-covered services furnished to the enrollee through the Original Medicare program, subject to the usual rules of payment.

Hospice coverage is effective immediately on the date of election; the reduced rate paid to the Medicare Advantage plan begins the next month (42 CFR §422.320).

Table I below summarizes the cost sharing and provider payments for services furnished to a Medicare Advantage plan enrollee who elects hospice.

Table I: Payments for services furnished to an enrollee who has elected hospice

Type of services	Enrollee coverage choice	Enrollee cost share	Payments to providers
Hospice program	Hospice program	Original Medicare cost share	Original Medicare
Non-hospice care, Parts A and B	Medicare Advantage plan or *Original* Medicare	Medicare Advantage plan cost share, if enrollee follows Medicare Advantage plan rules[3]	Original Medicare[2]
		Original Medicare cost share, if enrollee does not follow Medicare Advantage plan rules[3]	Original Medicare
Non-hospice care,[1] Part D	Medicare Advantage plan (if applicable)	Medicare Advantage plan cost share	Medicare Advantage Organization (MAO)
Supplemental	Medicare Advantage plan	Medicare Advantage plan cost share	MAO

Please see the following resources for additional information:

- The Social Security Act, section 1853(h)(2)(B); and
- The Medicare Claims Processing Manual, chapter 11 - Processing Hospice Claims, section 30.4

1. The term "hospice care" refers to original Medicare items and services related to the terminal illness for which the enrollee entered the hospice. The term "non-hospice care" refers either to services not covered by original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.
2. If the enrollee chooses original Medicare for coverage of covered, non-hospice-care, original Medicare services and also follows MA plan requirements, then, the enrollee pays plan cost-sharing and original Medicare pays the provider. The MA plan must pay the provider the difference between original Medicare cost-sharing and plan cost-sharing, if applicable.
3. An HMO enrollee who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost-sharing; a PPO enrollee who receives services out of network has followed plan rules and is only responsible for plan cost-sharing. The enrollee need not communicate to the plan in advance his/her choice of where services are obtained.

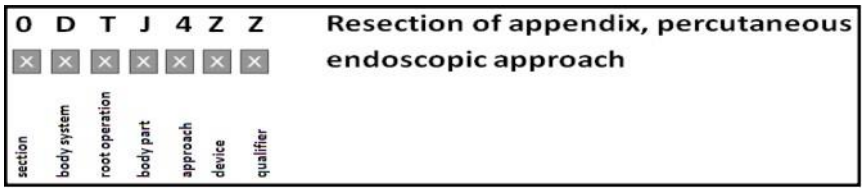
ICD-10 Diagnosis and Procedure Code Reporting

On January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases, 10th Revision (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.

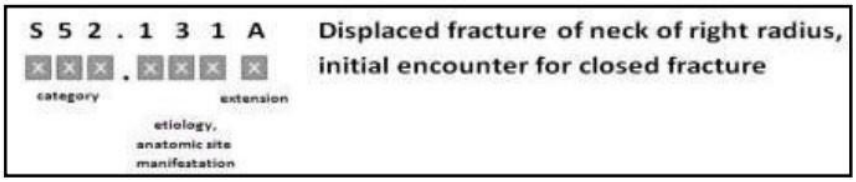
HSS released a rule on July 31, 2014, finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearing houses to transition to ICD-10.

ICD-10 consists of two parts:

1. ICD-10-Clinical Modification (CM) for diagnosis coding is for use in all U.S. health care settings. It uses three to seven characters instead of the three to five characters that were used with ICD-9-CM, adding more specificity.



2. ICD-10-Procedure Coding System (PCS) for inpatient procedure coding is for use only in U.S. inpatient hospital settings. It uses seven alphanumeric characters instead of the three or four numeric characters that were used with ICD-9-CM, adding more specificity and making them substantially different.



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

ICD-10 will affect diagnosis and inpatient procedure codes for everyone covered by the Health Information Portability and Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims.

Billable Versus Non-Billable ICD-10 Codes

- A billable ICD-10 code is defined as a code that has been coded to its highest level of specificity.
- A non-billable 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, it will be rejected.

Example: Billable ICD-10 code with corresponding non-billable codes.

Billable ICD-10 codes	Non-billable ICD-10 codes
M1A.3110 - Chronic goutdueto renal impairment, right shoulder, without tophus	M1A.3 - Chronic gout due to renal impairment
	M1A.311 - Chronic gout due to renal impairment, right shoulder

Note: 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 concern to CCQI@Cigna.com. Provide the patient's name and diagnosis code so that the code can be researched and retracted, if appropriate.

Visit MedicareProviders.Cigna.com > Provider Education > Documentation and Coding Resources.

Provider Claims Dispute Process and Appeals

Provider Claims Dispute Process

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. They must be received within the time frame 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 on the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in your Cigna agreement.
- You may appeal a previous decision not to pay for a service. For example, you may appeal claims denied for no prior 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 their behalf. This may be done through an Appointment of Representative Form.

Submit an Appeal

To request an appeal, complete the appropriate form.

- Contracted Post Service Appeal and Claim Dispute Form *(All health plans, including Arizona PPO plans)*
- Contracted Post Service Appeal and Claim Dispute Form *(Arizona HMO plans only)*

Be sure to attach medical records and submit your appeal in one of the following ways:

- Via secure email to SOL@HealthSpring.com, or
- Fax based on the appeal type in the table below.

For large medical record files, you may mail or fax the appeal request form attached to a CD containing medical records to the appropriate address listed below.

Appeal type	Mailing address	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 Independent Review Entity	PO Box 188083 Chattanooga, TN 37422	855.594.4423
Fast Track appeals (Quality Improvement Organization)	PO Box 188084 Chattanooga, TN 37422	855.594.4432
Participating provider appeals (post-service)	PO Box 188085 Chattanooga, TN 37422	855.699.8985
Arizona payment disputes (HMO only)	Cigna Attn: Provider Payment Disputes PO Box 38639 Phoenix, AZ 85069	860.731.3463

Claim Disputes and Reconsiderations

You have up to 180 days from the claim payment date to request a reconsideration. You may request a 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 for matters concerning coordination of benefits, timely filing, or missing information.

Payment retractions, underpayments, overpayments, and coding disputes should also be addressed through the claim dispute or reconsideration process. Cigna will review your request, as well as your provider record, to determine whether your claim was paid correctly.

Coordination of Benefits

Coordination of benefits (COB) is the process of determining and reconciling individual payer liability for reimbursement when a customer is eligible for benefits under more than one insurance company or other payer type (e.g., Medicare/Medicaid). Terms and conditions within the Summary of Benefits for each plan will generally dictate which payer is primary, secondary, or tertiary and any mathematical formula associated for calculating each pay portion of coverage.

Coordinating payment of these plans will provide benefit coverage of up to but not exceeding 100 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.

Terms and Definitions

Term	Definition
Allowable expense	Any expense that is customary or necessary for health care services provided and covered by the customer's health care plan.
Conclusion	COB applies the NAIC rules to determine which plan is primary, secondary, or tertiary when alternate insurance coverage exists. All plans must adhere to the structure set forth in the Model COB regulations. Medicare Secondary Payer (MSP) provisions apply for Medicare customers under certain conditions.
Order of Benefit Determination Rule	When applied to a particular customer covered by at least two plans, this rule determines the order of responsibility each plan has with respect to the other plan in providing benefits for the customer. By applying the NAIC rules, it will be determined if a plan will have primary, secondary, or tertiary responsibility for a person's coverage with respect to other plans by applying the NAIC rules.
Medicare Secondary Payer (MSP)	MSP refers to situations where Medicare does not have primary payment responsibility. Specifically, Medicare pays second and another entity or insurance company has responsibility to pay before Medicare.
Primary	The primary payer is responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists.
Secondary	The secondary payer 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).

Medicare Primary Versus 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 is:	And the below condition exists –	The below program pays first.	The below program pays secondary:
Age 65 or older and covered by a group health plan through current employment or a family customer's current employment	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more employees	The group health plan pays primary	Cigna / Medicare pays secondary
Age 65 or older and covered by a group health plan through current employment or a family customer's current employment	The employer has less than 20 employees	Cigna / Medicare pays primary	Group health plan pays secondary
Entitled based on disability and is covered by a large group health plan through their 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 pays primary	Cigna / Medicare pays secondary
Entitled based on disability and is covered by a large group health plan 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 pays secondary
Age 65 or older or entitled based on disability and has retirement insurance only	(The number of employees does not matter)	Cigna / Medicare Pays primary	Retirement insurance pays secondary
Age 65 or older or is entitled based on disability and has Consolidated Omnibus Budget Reconciliation Act (COBRA coverage)	(The number of employees does not matter)	Cigna / Medicare pays primary	COBRA pays secondary

Basic Processing Guidelines for COB

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

When Cigna is the primary insurance:

- Collect the copayment required under the customer's Cigna Medicare Advantage plan.
- Submit the claim to Cigna first.
- Be sure to have your patient sign the assignment of benefits sections of the claim form.
- Submit a copy of the claim with the remittance advice to the secondary payer for adjudication once payment or a remittance advice has been received from Cigna.
- Cigna Medicare Advantage is a total replacement for Medicare. Medicare cannot be a secondary payer when customers have Cigna Medicare Advantage plans.
- Medicaid will not pay the copayment for Cigna customers.

When Cigna is the secondary insurance:

- All Cigna guidelines must be met in order to reimburse the provider (e.g., prior authorization and referral forms).
- Collect only the copayments required.
- Be sure to have your patient sign the "assignment of benefits" sections of the claim form. Once you receive payment or the EOP from the other payers, submit to Cigna another copy of the claim with the EOP for reimbursement. Note all authorization numbers on the claims and attach a copy of the referral form, if applicable.

Workers' compensation

Cigna does not cover workers' 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 workers' compensation payer 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 that has paid benefits for its insured, the health plan is substituted in place of its insured. The health plan can make legal claims against the party that should be responsible for paying those bills – for example, the person who caused the insured's injuries and their third-party payer (e.g., property and casualty insurance, automobile insurance, or workers' compensation payer).

The Basic Processing Guidelines for COB will still apply in the filing of the claim. Cigna may pay conditionally, subject to later recovery if there is a subsequent payment, settlement, or judgment award from the liable party. Patients who may be covered by third-party liability insurance should only be charged the required copayment.

The bill should be submitted to the liability payer. The provider should submit the claim to Cigna with any information regarding the third-party payer (e.g., auto insurance name, lawyer's name). All claims will be processed in accordance with the usual claims procedures.

Cigna uses contracted vendors for review and investigation of all possible subrogation cases. The vendors coordinate all requests for information from the customer, provider, and attorney name(s) and office(s), and assists with settlements.

If you have questions related to a subrogated case, call Customer Service at **855.744.0223**. An experienced subrogation representative from one of our vendors, The Rawlings Group or Cotiviti will provide assistance.

Medicaid COB

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

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 state-specific Medicaid website.

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.

You can verify your patients' Medicaid eligibility 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 percent 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 standard or through spending down excess income to the Medically Needy level.

Specified Low-Income Medicare Beneficiary (SLMB Only)

An SLMB is an individual who is entitled to Medicare Part A, has income that exceeds 100 percent FPL but is less than 120 percent 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 percent FPL but less than 135 percent FPL, has resources that do not exceed three times the SSI limit, and 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 percent federally funded and the total expenditures are limited by statute. QIs are not otherwise eligible for full Medicare coverage.

Other Full Benefit Dual Eligible (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 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 eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200 percent FPL and resources may not exceed twice the SSI limit. QDWIs are only eligible for Medicare.

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 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

Our HMO plans may only cover hearing, vision, and acupuncture services when supplied by providers that participate in the applicable network listed above.

Our PPO plans may only cover hearing, vision, and acupuncture services at the in-network benefit and cost-sharing levels when supplied by providers that participate in the applicable network listed above. Providers are encouraged to call the customer service number on the customer's ID card if they have any questions around services that may or may not be covered.

Please inform customers if you participate in any of these vendor-specific networks before providing related services. To explore participating in these vendor-specific networks, contact your Network Operations Representative or visit the vendors' websites.

- Hearing Care Solutions: HearingCareSolutions.com > For Providers > Request Info
- EyeMed: EyeMed.com > Providers > Providers Home > Get More Information
- American Specialty Health: ASHLink.com > Join Our Network > Providers

eviCore healthcare

Cigna works with eviCore healthcare, a specialty medical benefits management company, to manage prior authorization of the services listed below.

High-tech radiology and diagnostic cardiology

- Computed tomography (CT) and CT angiography (CTA)
- Magnetic resonance imaging (MRI) and magnetic resonance angiogram (MRA)
- Positron emission tomography (PET)
- Nuclear cardiology imaging
- Diagnostic cardiology
- Stress echoes

Medical oncology (excludes Part D coverage) and radiation therapy

- Medical oncology medications
- Outpatient radiation therapy treatment plans for both cancerous and noncancerous diagnoses.

Musculoskeletal procedures

- Hip, knee, and shoulder surgery
- Pain management services: Epidural steroid injections, facet injections, epidural adhesiolysis, spinal cord stimulator, pain pumps, and radio frequency ablation

Post-acute care, home health care, and durable medical equipment

- Post-acute care
- Skilled nursing facilities
- Inpatient rehabilitation facilities
- Long-term acute care facilities
- Home health care[4]
- Durable medical equipment[4]

Important notes:

- 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, CPT code lists, and additional resources can be located by visiting: eviCore.com/Resources/Healthplan/Cigna-Medicare.
- Please see the Medicare Advantage Provider Quick Reference Guide for information on submitting prior authorization requests to eviCore.

CLIA Certification Requirement 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 health care 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 laboratory certification level does not support the billed service code.

Additional information regarding CLIA may be found on the CMS website (CMS.gov) > Medicare > Quality, Safety & Oversight – Certification & Compliance > Clinical Laboratory Improvement Amendments (CLIA).

4 Excludes Arizona (for durable medical equipment and home health care), as well as specific providers who are fully delegated for utilization management and care management.

Clinical Review Services

Overview

Cigna's Clinical Review 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 or a third party delegated by Cigna to administer utilization management (the "delegated utilization management agent") will provide a full range of customary utilization review and care management services and, except in the case of an emergency medical condition, provide prior authorization for those services if required by the customer's benefit plan, including hospital inpatient stays or confinement. You are responsible to participate in and comply with Cigna's utilization management program requirements and, to the extent applicable, the delegated utilization management agent's utilization management program, and provide medical records and other information, including access to electronic medical records (EMRs), as requested.

Cigna's Clinical Review 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, providers, 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. It is Cigna's goal to:

- Ensure that services are authorized at the appropriate level of care and covered under the customer's health plan benefits.
- Monitor utilization practice patterns of Cigna's contracted physicians, hospitals, ancillary services, and specialty providers.
- Provide a system to identify high-risk customers and ensure that appropriate care is accessed.
- Provide utilization management data for use in the process of recredentialing providers.
- Educate customers, physicians, contracted hospitals, ancillary services, and specialty providers about our goals for providing quality, value-enhanced managed health care.
- Improve utilization of our Cigna's resources by identifying patterns of overutilization and underutilization that have opportunities for improvement.

Clinical Review Services

The Clinical Review Services department consists of nonclinical and clinical support staff trained to receive requests via portal, fax, telephone, and mail. Pertinent information will be requested to efficiently and accurately process the medical necessity determination. Upon submission of the request, please be prepared with all necessary information noted below. Information required for a determination may include, but is not limited to:

- Customer name and identification number.
- Location of service (e.g., hospital or ambulatory care setting).
- PCP name and TIN or Provider Identification Number (PIN).
- Requesting physician name, including NPI.
- Servicing physician name, including NPI.
- Date of service.
- Accurate diagnosis.
- Service, procedure, or surgery description, along with CPT code(s) or HCPCS code(s).
- Clinical information supporting the need for the service to be rendered.

As necessary, requests will be forwarded to clinically licensed staff to complete a review to ensure benefit coverage, medical necessity, and 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.

They may also make a decision based on administrative guidelines. The Medical Director or Pharmacist, in making the decision, may discuss suggest alternative covered services with the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service, or extension of stay, Cigna or the delegated utilization management agent 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 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 National Committee for Quality Assurance (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. To request clinical criteria, call **800.230.6138**, Monday–Friday, 8:00 a.m.–5:00 p.m. CT.

Cigna gives providers the opportunity 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 provider to receive additional clinical information that may be helpful prior to initiating a formal appeal. Cigna will advise the treating provider of the availability of this process when notification of the prior authorization denial is given.

Prior authorization decisions cannot be altered with the peer-to-peer process. 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.

Departmental functions:

- Prior authorization
- Concurrent review
- Retrospective review
- Discharge planning
- Population health operations program goals
- Continuity of care

Prior Authorization

Cigna requires prior authorization of certain services, medications, procedures, and equipment prior to performing or providing the service to prevent unnecessary utilization while safeguarding customer access to the most appropriate medically necessary care. The prior authorization is typically requested 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, 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 customer 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.

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.

Please refer to the 2023 Authorization Requirements. If you are uncertain about the prior authorization requirement for a specific procedure, you may also outreach to Provider Customer Service.

To access the prior authorization forms, go to MedicareProviders.Cigna.com > Find a Form > Prior Authorization Request Forms. Please complete the form in its entirety and attach pertinent clinical information.

Note that 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 the customer's eligibility, plan participation 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.

How to request prior authorization

Cigna offers a variety of ways to request prior authorization, including:

- Provider portal (HSConnect)
- Phone or fax
- Mail – Cigna Healthcare Medicare
  Attn: Precertification Dept.
  500 Great Circle Road
  Nashville, TN 37228

Log in to HSConnect (except Arizona providers) or contact Provider Customer Service to verify a customer's benefits, coverage, and eligibility. After confirming their eligibility and the availability of benefits, providers should submit all supporting documentation.

Phone and fax

Contact	Phone	Fax
Behavioral Health (all markets)	866.780.8546	866.949.4846
Drugs/Biologics Part B	888.454.0013	877.730.3858
CareAllies	844.359.7301	866.233.6235
Clinical Operations	800.453.4464	866.287.5834

Phone lines are staffed Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

The Clinical Review Services department, under the direction of licensed nurses, clinical pharmacists, and medical directors, documents and evaluates requests for prior authorization, including:

- Confirmation that the customer is eligible for Cigna health plan coverage 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 Clinical Review Services 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 time frames.

It is essential to submit clinical information at the time of the request. Cigna may outreach to you for information needed to make a determination. Requests received without supporting documentation may experience delays in processing up to the regulatory time frames, as CMS rules require that appropriate information be requested before decisions are rendered. See the Prior authorization request and time frames section for details regarding decision and notification time frames.

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 nonemergency care, the PCP should be contacted for direction. The customer may be financially responsible for payment of nonemergency care that is rendered. Customers may utilize urgent care facilities to treat conditions that are nonemergencies but require immediate treatment. 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.

Prior authorization forms

To access our prior authorization forms, go to MedicareProviders.Cigna.com > Find a Form > Prior Authorization Request Forms. It is important to use the forms when faxing a prior authorization request (along with the supporting clinical information) to help assure we have all the information needed to make a determination.

We update prior authorization requirements on a quarterly basis to align with program or CPT and HCPCS code changes. Therefore, it is important to check the prior authorization requirements before delivering planned services.

Prior authorization request 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 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.

To help us meet our customers' urgent care 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.

Routine

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

Medical necessity hierarchy

The hierarchy of decision includes that the service must be:

- A covered benefit in the customer's Evidence of Coverage,
- A benefit that is not otherwise excluded, and
- Appropriate and medically necessary.

The hierarchy of references includes:

- Laws – Title 18 of the Social Security Act
- Regulations – Title 42 Code of the Federal Regulations [CFR])
- National coverage determinations
- Medicare Benefit Policy Manual – Internet Only Manual (IOM) 100-02
- Local coverage determinations
- CMS coverage guidelines in interpretive manuals and IOM sub-manuals
  - Pub 100-04 Medicare Claims Processing
  - Pub 100-08 Medicare Program Integrity
  - Pub 100-10 Quality Improvement Organization
  - Pub 100-16 Medicare Managed Care Manual
- Durable Medical Equipment Medicare Administrative Contractor
- Program Safeguard Contractor for local coverage determinations
- Cigna coverage policies
  - Cigna Coverage Policy Unit
  - eviCore co-branded
  - Drug and biologic coverage policies (Express Scripts)
- Vendor partner guidelines
- NCCN Clinical Practice Guidelines
- Part B drug and biologic coverage parity and step therapy policies
- Cigna standards and guidelines and medical necessity criteria for behavioral health
- MCG (most recent edition)
- Supplemental benefits and limitations as outlined in the customer's Evidence of Coverage
- U.S. Food & Drug Administration (FDA)-approved indications for medications not outlined in specific local coverage determinations
- Other major payer policy and peer-reviewed literature
- Utilization management policies and procedures (such as for network adequacy, continuity of care, and transition of care)
- Additional Medical Director resources:

- Hayes
- Wolters Kluwer Clinical Drug Information Lexi-Drugs (up to date)
- Medical inquiry database

Discharge Planning

Discharge planning is a critical component of the process that begins with an early assessment of the customer's potential discharge care needs to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the customer and their family for any discharge needs, along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. Cigna's Concurrent Review staff will coordinate with the facility's discharge planning team to assist in establishing a safe and effective discharge plan.

Inpatient coordination of care and 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 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 of services 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.

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, and 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 medical 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 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 unless otherwise specifically stated in your provider services agreement. Observation services in excess of 48 hours are subject to administrative denial.

Cigna requires admission notification for the following:

- Elective admissions
- Emergency room, urgent observation, and acute admissions
- Intent to transfer to acute rehabilitation, long-term acute care, or a skilled nursing facility, as these admissions require prior authorization
- 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 professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

Cigna's preferred method for concurrent review is EMR access. We can also receive concurrent review documentation via fax. We encourage live dialogue between our Concurrent Review Nursing staff and the facility's utilization management staff to assist with discharge planning and needs. We should receive admission notification and clinical information within 24 hours of admission or observation status. If we do not receive clinical information within 72 hours of admission or the last covered day, we will review the case for medical necessity with the information we have available.

Facilities may submit the customer's clinical information within 24 hours of notification using the appropriate contact information below.

Area	Portal	Phone	Fax
Inpatient	N/A	888.454.0013	866.234.7230
Texas CareAllies Inpatient	N/A	844.359.7301	888.205.9577
eviCore healthcare *(preferred method)*	www.eviCore.com/ep360	Post-acute care: 800.298.4806 Home health: 800.298.4806 Durable medical equipment: 866.686.4452	Post-acute care: 800.575.4429 Home health: 855.826.3724 Durable medical equipment: 866.663.7740

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 provider or facility upon request. Cigna will render a determination within 24 hours of receipt of complete clinical information. The Cigna 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 Medical Director reviews all acute confinements that do not meet medical necessity criteria and issues a determination. If the 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 or ordering provider, and customer) of the adverse determination via a notice of denial.

Cigna's Health Services department complies with individual facility contract requirements for concurrent review decisions and time frames. Cigna's nurses, utilizing CMS guidelines and nationally accepted, evidence-based review criteria, will conduct the medical necessity review.

Cigna is responsible for final prior authorization.

Adverse determinations – concurrent review

Rendering of adverse determinations (denials)

The Cigna Clinical Operations 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.

Only the 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 limit an admission or deny an extension of stay, Cigna notifies the requesting provider of partial approval of service, documenting the original request that was denied and, if applicable, the alternative approved service, along with the process for appeal. If the Medical Director makes a determination to deny an admission, Cigna notifies the requesting provider and the customer of the denial of service, documenting the denial rationale and the process for appeal.

Cigna gives providers the opportunity to discuss adverse determinations with the Medical Director who made the decision.

The purpose of the peer-to-peer conversation is to give the ordering or treating provider an opportunity to discuss the case directly with the reviewer and provide additional clinical information that may be helpful prior to initiating a formal appeal. Cigna will advise the treating provider of the availability of this process when notification of the prior 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 business days following discharge to initiate 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 the 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 urgent concurrent decisions: Within 72 hours of the request.[5]
- For post-service decisions: Within 30 calendar days of the request.

Retrospective review

Retrospective review is the process of determining coverage for clinical services by applying guidelines and criteria to support the claim adjudication process after the prior authorization or concurrent review time frame has passed. Listed below are the only scenarios in which retrospective requests can be accepted.

- Prior authorizations for claims billed to an incorrect payer.
  - If you have not submitted the claim to Cigna yet and received a denial, you can request a retrospective prior authorization from Clinical Review Services within two business days of receiving the remittance advice from the incorrect payer.
  - If you have already submitted the claim to Cigna and received a denial, you cannot request a retrospective prior authorization; however, you can request an appeal (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. The retrospective prior authorization request and applicable clinical information must be submitted to the Clinical Review Services department within one business day of the start of care.

In accordance with Cigna policy, retrospective requests for prior authorizations not meeting the scenarios listed above will not be accepted and claims may be denied for payment.

Readmission

The Clinical Review Services 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 Clinical Review Services 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.
Readmissions that occur on the same day are subject to being combined concurrently.

Readmission Quality Program

Cigna's Readmission Quality Program applies to readmissions that occur as an acute inpatient admission for a same or similar diagnosis at a facility under the same Taxpayer Identification Number (TIN) or contract.

Patient engagement and follow-up during the 30-day period following discharge can help reduce readmissions, which is a national goal that the Centers for Medicare & Medicaid Services (CMS) supports to improve the quality of care of Medicare Beneficiaries. In accordance with your contract, you may not bill the customer for covered services denied by Cigna.

Cigna will reimburse for readmissions for the same or similar diagnosis at a facility under the same Taxpayer Identification Number (TIN) as follows:

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

1. **Readmissions within 48 hours from the date of discharge from the original acute inpatient admission (referred to as the index admission):**

   The facility will *not* be reimbursed for the readmission regardless of the readmission length of stay. The CMS generally considers a short-term readmission for the same or similar diagnosis to be the result of a process failure in discharge planning or the patient not being clinically stable at the time of the original discharge. Cigna Medical Directors will not conduct medical necessity reviews of admissions within 48 hours from the date of discharge from the original acute inpatient admission. A Cigna MA Medical Director will review the readmission to determine if a same or similar diagnosis is present.

2. **Readmissions within 3-31 days from the date of discharge from original acute inpatient admission (referred to as the index admission):**
   The facility will receive one DRG payment for both confinements, which will be the higher weighted of the two DRG admissions. The days, diagnoses, procedures and all associated billed items or services from each stay will be accounted for in the single DRG payment. Cigna MA Medical Directors will conduct medical necessity reviews of admissions within 3-31 days from the date of discharge and evaluate whether a same or similar diagnosis is present as well as a modifiable cause.

   For per diem: 100% per day of first admission, 85% per day of the readmission.

   If there is a second or more readmission(s) that occur within the original 31 day window from the original index admission discharge, then this will likewise bundle into the original admission, if the above parameters are met. A new index readmission is not set until a full 31 days has elapsed.

Program exclusions include:

- Initial admission that occurs in observation.
- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed according to the facility agreement.
- Readmissions for patients undergoing active chemotherapy treatment or who are in the immediate post-transplant period (31 days) are excluded from this program.
- Planned and approved elective admissions that occur within 31 days of acute inpatient discharge are reimbursed according to the facility agreement.
- Transfers from out-of-network to in-network facilities.
- Transfers of patients to receive care not available at the first facility.
- Admissions with a discharge status of “left against medical advice.”
- Behavioral Health, Long Term Acute Care and Inpatient Rehab admissions.

All acute admissions are subject to this program unless your contract specifically dictates otherwise

Skilled nursing facility care and levels

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

Services and supplies that are specifically excluded from skilled nursing facility consolidated billing are excluded from the level classifications below and should be billed in accordance with CMS billing guidelines.

The standard services listed below are included in all levels of care.

- Semiprivate room
- Meals
- Provisions of enteral and parenteral nutrition
- 24-hour nursing care and rehabilitation nursing services
- Pharmacy
- Routine medication
- Supplies
- Pharmacy consultation
- Standard durable medical equipment
- 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, or observation by skilled nursing or rehabilitation staff
- Case management
- Recreational therapy
- Social services

Notes:

- 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, Cigna, or the delegated utilization management agent within seven days of discharge will be reimbursed at Level I rates.
- Post-acute care facilities are required to submit concurrent review requests two days prior to the current authorization end date.

Service	Definition
SNF Level I Rev Code 191	Includes the standard services listed above and all of the following services: • Minimum three hours per day direct skilled nursing intervention • No active treatment of comorbidities or stable comorbidities • Assessment of vitals and body systems (required one to two times per day) Must also include one or more of the following services: • IV infusion – Pump and supplies, fluids for hydration • Pain management administered intramuscular or subcutaneous • Feeding tube post placement
SNF Level II Rev Code 192	Includes the standard services listed above, Level I services, and all of the following services: • Three to six hours per day direct skilled nursing intervention • Active treatment of comorbidities (required) • Assessment of vitals and body systems (required two to three times per day) Must also include one or more of the following services: • Wound care for the following treatments: ○ Surgical and amputation sites (requires 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 (requires two treatments per day) ○ Burns with grafting (requires mechanical debridement or two treatments per day) • Acute colostomy, ileostomy, super-pubic catheter care, or peritoneal dialysis, including training and supplies • Tracheostomy – stable • IV infusion for pain management • Therapy (physical, speech, occupational)
SNF Level III Rev Code 193	Includes the standard services listed above, Level I and II services, and all of the following services: • Three to six hours per day direct skilled nursing intervention • Active medical care and treatment of comorbidities (required), with the potential for the comorbidities to affect the treatment plan • Assessment of vitals and body systems is required three to four times per day Must also include one or more of the following services: • IV infusion via subclavian line, central line, peripherally inserted central catheter, including pump, maintenance, and supplies • IV medication with an Average Wholesale Price less than $100 per day all doses combined • Total parenteral nutrition administration • Wound care for the following treatments: ○ Decubitus – multiple Stage II sites (one or more treatments per day) ○ Decubitus – Stage III or greater (one or more treatments per day) ○ Mechanical or sharp debridement of necrotic tissue, excludes autolytic and/or enzymatic debridement, sterile packing and/or compression bandaging drainage tubes ○ 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 (physical, speech, occupational) ○ Therapy evaluations (physical, occupational, speech), as indicated ○ Therapy treatments greater than two hours per day

SNF Level IV Rev Code 194	Includes the standard services listed above, Level I, II, and III services, and all of the following services: • Intensive care – six to eight hours per day skilled nursing and technical intervention • Active medical care and treatment of comorbidities (required) • No active treatment of comorbidities or stable comorbidities. • Assessment of vitals and body systems (required four to six times per day). Must also include one or more of the following services: • Chronic vent care, including supplies, blood gases, pulse oximetry, pulmonary testing, and pulmonary rehabilitation) • Tracheostomy care with frequent suctioning/coughing, greater than three times per shift • Administration of chemotherapy or IV medication with an Average Wholesale Price greater than $100 per day, all doses combined • Complex wound care and skin disorders ○ Stage IV decubitus (two or more treatments per day) ○ Multiple wound sites requiring debridement, packing, or sterile technique
SNF Level V Rev Code 199	Includes the standard services listed above, Level I, II, III, and IV services, and all of the following services: • Intensive care of six to eight hours per day skilled nursing and technical intervention • Active medical care and treatment of comorbidities (required) • No active treatment of comorbidities or stable comorbidities. • Assessment of vitals and body systems (required four to six times per day vent care • Vent care for weaning; chronic vent care, including supplies, blood gases, pulse oximetry, pulmonary testing, pulmonary rehabilitation, and documented weaning trials

Notice of Medicare Non-Coverage

A Cigna or delegated utilization management agent reviews all ongoing skilled nursing services that do not meet medical necessity criteria and issues a determination. If the Cigna Medical Director deems that a continued stay is not medically necessary, the Medical Director will issue an adverse determination (a denial).

Cigna or the delegated utilization management agent will issue a Notice of Medicare Non-Coverage (NOMNC) to the skilled nursing facility with adverse organization determinations or denials when it is determined 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 or power of attorney at least two 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 that the customer, authorized representative, or power of attorney signs the notice within the specified time frame. The NOMNC includes information on a customer's rights to file a fast-track appeal.

Referral Guidelines

HMO Plans

The PCP is often the customer's primary point of entry into the health care delivery system for all outpatient specialist care. For select HMO plans, the PCP may be required to obtain a referral for most outpatient specialist visits for Cigna customers. The customer's ID card will indicate if a referral is required, with the exception of Arizona.

- PCPs should make referrals to Cigna Medicare Advantage network-participating specialists.
- Nonparticipating specialist 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
  - Customer date of birth
  - Customer ID
  - PCP name
  - Specialist name
  - Date of referral
- Number of visits requested.
- Diagnosis code

If a customer is in an active course of treatment with a nonparticipating specialist at the time of enrollment into a Cigna Medicare Advantage plan, a PCP referral is not required. However, prior authorization must be obtained from the Clinical Operations department. For further details, please refer to the Continuity of Care section.

Please note: If a customer needs care from a specialist, it is preferred that they obtain the referral from their PCP.

PPO Plans

Referrals are not required for PPO plans. However, before receiving services from providers that do not participate in the network, the customer may want to ask for a pre-visit coverage determination.

Plans that Require Referrals by State

In the table below, checkmarks indicate the types of Cigna Medicare Advantage plans that are available in each market listed. Diamonds indicate plans that require a referral to see a network-participating specialist, with the exception of behavioral health (outpatient mental health) specialists for an HMO plan.

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

How to Obtain a Referral

There are four ways a PCP can obtain a referral to a specialist:

- **HSConnect** *(preferred method)*. Our provider portal is available 24 hours a day, 365 days a year. You can submit (and follow) the request online, which will help ensure accurate and timely processing of referrals.
- **Fax.** Complete the referral form and fax it to our Referral department.
- **Mail.** Complete the referral form and mail it to: Cigna Healthcare Medicare, Attn: Precertification Dept., 500 Great Circle Road, Nashville, TN 37228
- **Phone.** If the referral is for an emergency, you may obtain a referral by phone by calling the appropriate phone number below for your state.

Market	Contact
Alabama	Phone: 800.962.3016
Arizona	N/A; Arizona plans do not require referrals.
Colorado, Utah, New Mexico, Oregon, and Washington	Phone: 800.230.6138
Florida	Phone: 800.962.3016
Southern Mississippi	Phone: 866.949.7103
Georgia (all counties except Catoosa, Dade, and Walker)	Phone: 866.949.7103, Fax: 855.420.4717
North Carolina	Phone: 866.949.7099
South Carolina	Phone: 866.949.7101
Kansas City	Phone: 888.454.0013
Tennessee, Northern Georgia, and Arkansas	Phone: 800.453.4464
Illinois, Ohio, and Indiana	Phone: 800.230.7298
Oklahoma City, Texas, and Southern Arkansas	Cigna prior authorization: • Phone: 800.511.6932 (toll free) or 832.553.3456 (local) • Fax: 888.856.3969 or 832.553.3426 (local) Durable medical equipment: • Phone: 800.511.6932 (toll free) or 832.553.3313 (local) • Fax: 888.205.8658
Delaware, Maryland, New Jersey, Pennsylvania, and Washington D.C.	Phone: 888.454.0013, Fax: 866.464.0707

PCP Referral Responsibilities

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

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 one is required one; we are unable to make exceptions to this requirement. To verify that a referral has been made, the specialist may log in to HSConnect, contact the customer's PCP, or call Cigna to verify.

Important note: The HSConnect provider portal is not available to Arizona providers at this time.

Referrals to Nonparticipating Providers

Cigna strives to ensure the quality of care delivered by network-participating providers. Referrals to nonparticipating providers are not recommended as the quality of care cannot be effectively monitored for our customers. Additionally, use of a nonparticipating provider may be excluded by the customer's benefit plan or negatively impact the customer's applicable cost-share. Cigna will consider a referral to a nonparticipating 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 alignment with access and availability standards).

Prior authorization is required for referrals to nonparticipating providers. 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 prior authorizations to providers, customers or their authorized representatives may request prior authorizations on their own behalf. For PPO plans, prior authorization is only required for in-network and out-of-network services listed at MedicareProviders.Cigna.com > Prior Authorization Requirements. This allows us to confirm that these services are covered and medically necessary for:

- Inpatient hospital and skilled nursing admissions[6]
- Outpatient procedures, services, and supplies

Population Health Management

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 and measurable, and have associated internal and external benchmarks against which progress is assessed and evaluated throughout the year. Plan demographic, epidemiologic, and survey data are used to select program objectives, activities, and evaluations.

Population Health Management Approach

Our population health management program is part of the broader population health management strategy. It is a comprehensive multidisciplinary approach to the management of customers across the spectrum of care with chronic, complex, and disease-specific care needs.

Key components of the population health management program are to provide early identification and intervention for customers with medical, pharmaceutical, or behavioral health needs who would benefit from:

- Improved self-management skills.
- Referrals to adjunct programs.
- Complex care management.

6 However, PPO customers requiring out-of-network care who meet the network and medical necessity criteria above must also request a prior authorization to ensure their applicable cost-share is applied.

- Assistance with coordinating plan benefits and/or community resources.
- Reduction in the frequency and/or intensity of a chronic illness exacerbation.
- Closure of gaps in preventive care measures.

Customers are stratified and identified for specific programs that meet their needs through a variety of mechanisms including referrals, data analysis for health resource patterns, and predictive modeling. Prevalence rates and comorbidities in each individual market's population of customers are evaluated for needed services.

Customers may be referred for evaluation based on their health risk assessment results or by their PCP, specialist, inpatient review nurse, or other ancillary services provider. Claim or encounter data, pharmacy data, laboratory results, data from the care management and utilization management process or care management (SNP) process, information from EMRs, and customer self-referral may also be used to identify customers for disease-specific programs. The care management program content includes all information and interventions that the organization directs at customers or providers to improve management of a condition or health maintenance (e.g., materials, customer reminders, scripts for phone calls).

How to Use Services

Customers 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.

Provider contact information

To refer a Cigna customer for care management or care coordinator services, please use the contact information below.

Phone: 866.382.0518, Option 2, Monday–Friday, 8:00 a.m.–5:00 p.m. CT
Email: CareManagementSupport@Cigna.com

Customer information

Our customers have access to information regarding the program via a brochure and website, and may self-refer. Our Population Health Operations 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 network-participating facilities, PCPs, and specialty care physicians, as well as behavioral health and alcohol and substance use disorder specialists, and an ancillary care network of providers. Each customer receives a provider directory annually giving in-depth information about how to find participating providers in their area (by ZIP code and specialty), how to select a PCP (if required), conditions under which out-of-area and nonparticipating providers may be seen, and procedures for when the customer's provider leaves the network. A toll-free Customer Service telephone number is provided that customers can call if they have any questions. Customers 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 Population Health Operations staff will work with you and your staff to meet the unique needs of each customer. Care 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 nonclinical barriers to care. In cases where provider referrals are necessary, care managers work closely with customers to identify appropriate providers, schedule visits, and secure transportation.

6 However, PPO customers requiring out-of-network care who meet the network and medical necessity criteria above must also request a prior authorization to ensure their applicable cost-share is applied.

Continuity of Care

Cigna's policy is to provide for continuity and coordination of care with medical providers 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 a disorder, render direct treatment, prescribe medication or 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 utilization management 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 providers 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, durable medical equipment, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other ongoing services) initiated prior to a new customer's enrollment for a period of up to 90 calendar days or until the PCP evaluates the customer and establishes a new plan of care. For additional information about continuity of care or to request prior authorization for such services, please review the Home Health Services section of this manual for contact information for care management services.

6 However, PPO customers requiring out-of-network care who meet the network and medical necessity criteria above must also request a prior authorization to ensure their applicable cost-share is applied.

Home Health Services

Cigna requires prior authorization of home health services and utilizes CMS guidelines and nationally accepted, evidence-based review criteria to conduct medical necessity review of services.

Following the completion of the initial assessment by the home health agency, the home health agency has seven calendar days from the initial visit to establish the care plan and must include all visits needed to establish the plan of care specific to the customer's needs when requesting prior authorization. Timely receipt of clinical documentation 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.

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). Cigna, the delegated utilization management agent, or designee will notify the provider and customer verbally and in writing of the adverse determination via notice of denial.

Cigna or the delegated utilization management agent will issue a NOMNC to the home health provider when an adverse determination is rendered resulting in an end to all skilled nursing 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 or power of attorney at least two 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 two 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 power of attorney signs the notice within the specified time frame. The NOMNC includes information on the 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 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.

Drugs/Biologics Part B (Medical Benefit)

Drugs/Biologics Part B are covered under the medical benefit in accordance with the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Managed Care Manual, Chapter 4. Requests for Drugs/Biologics Part B prior authorization are processed in accordance with Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Prior authorization requirements for Drugs/Biologics Part B are available on the Cigna Medicare Advantage Providers website (MedicareProviders.Cigna.com).

Prior authorization requirements ensure appropriate drug utilization by following 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.

6 However, PPO customers requiring out-of-network care who meet the network and medical necessity criteria above must also request a prior authorization to ensure their applicable cost- share is applied.

Criteria Hierarchy for Medical Necessity

The hierarchy of decision includes that the service must be:

- A covered benefit in the customer's Evidence of Coverage,
- A benefit that is not otherwise excluded, and
- Appropriate and medically necessary.

The hierarchy of references includes:

- The law (Title 18 of the Social Security Act)
- Regulations (Title 42 Code of the Federal Regulations)
- National coverage determinations
- Medicare Benefit Policy Manual (IOM 100-02)
- Local coverage determinations
- Express Scripts Medicare Advantage policies
- Express Scripts commercial policies
- Cigna coverage policies
- Cigna Coverage Policy Unit
- eviCore co-branded
- MCG (most recent edition available)
- Compendium:
  - NCCN Drugs and Biologics
  - Truven Health Analytics Micromedex (DrugDEX)
  - Wolters Kluwer Clinical Drug Information Lexi-Drugs (up to date)
  - American Hospital Formulary Service-Drug Information (AHFS-DI)
  - Elsevier/Gold Standard Clinical Pharmacology

Prior Authorization

Obtain prior authorization for Drugs/Biologics Part B using one of the methods below.

- Portal – HSConnect: HSConnectOnline.com/login.aspx (*excludes Arizona providers)*
- Phone: 888.454.0013 (Drugs/Biologics Part B Prior Authorization department)
- Fax: 877.730.3858 (Drugs/Biologics Part B Prior Authorization department)

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

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

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 customers. Step therapy is a program that requires patients to try lower-cost options before "stepping up" to higher-cost. 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 customers.

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

Prior authorization requirements, a step therapy quick reference guide, and forms are available at MedicareProviders.Cigna.com > Find a Form.

Outpatient Observation Notice

Contracted Medicare 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 an 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.

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 Medicare Advantage network providers. Cigna’s credentialing standards and processes are designed to comply with CMS regulations and applicable laws.

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 their license or certification under state law. 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 network participation with Cigna. No provider can be assigned a Cigna 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 be recredentialed at least once every three years (every 36 months) to maintain participation status.

Providers and Organizational Network Selection Criteria

Providers

We utilize specific selection criteria to ensure that providers who apply to participate in the Cigna Medicare Advantage network 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.
- Holds a current, valid, and unrestricted federal Drug Enforcement Agency and state controlled-substance certificate, as applicable.
- Is board certified or has completed appropriate and verifiable training in the requested practice specialty. Has and maintains malpractice insurance of at least $1,000,000 per incident and $3,000,000 aggregate, unless state or federal laws require otherwise.
- Has an NPI number.

- Has not been excluded, suspended, precluded, and/or disqualified from participating in any Medicare, Medicaid, or other government health-related program.
- Is not currently opted out of Medicare.
- Has admitting privileges, as applicable.

Application process

- Complete and submit a Network Interest Form to Network Operations. Network Operations will review each provider 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 Form W-9 that must be completed and signed. If the provider utilizes the CAQH Proview system, they 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, they may call CAQH at **888.599.1771** to request a paper application. An application form may also be included in the credentialing or contract packet, and must be completed and returned by the provider along with the contract.
- All credentialing applications must contain the following information to be considered complete:
  - All current and active state medical licenses, Drug Enforcement Agency certificate(s), and state-controlled substance certificate, as applicable.
  - Evidence of current malpractice insurance, including the effective and expiration dates of the policy and term limits.
  - 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 months.
  - Sufficient additional information and explanations if any of the professional disclosure questions are answered ”yes” on the application.
  - Appropriate clinical detail for all pending malpractice cases or those that resulted in a settlement or other financial payment within the last five years.
  - Current and complete hospital affiliation information on the application. If there are no hospital admitting privileges and the specialty warrants them, a letter detailing the alternate coverage arrangement(s) or the name of the alternate admitting physician must be provided.
  - Signed and dated application.
- Once a completed and signed contract or credentialing packet has been received, Network Operations will submit a request to the Credentialing department to start the credentialing verification process, and forward any application information that was received.
- The Credentialing department will log all received applications and begin the verification process. Applications will be processed by the date received unless Network Operations indicates that a specific customer or network need requires more expedited processing.
- Once the credentialing process is complete, Network Operations will send 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 participation effective date shall be denied.

Provider rights

You have the 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. You may submit a written request to review their file information at least 30 days in advance at which time Cigna will establish a time for you to view the information at Cigna’s offices.
- Correct erroneous information when information obtained during the credentialing process varies substantially from the information you submitted. In these instances, the Credentialing department will notify you in writing of the discrepancy within 30 days of receipt of the information. You must submit a

written response and any supporting documentation to the Credentialing department to either correct or dispute the alleged variation in your application information within 30 days of notification.
- Be informed of the status of your application upon request. You may request the status of the application by calling Provider Customer Service 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. We will respond to written and electronic requests within 15 business days.

Organizational provider

When assessing organizational providers for participation in the Cigna Medicare Advantage network, we utilize the following criteria:

- Is 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, and/or has received a passing score on Cigna's credentialing site review.
- If not accredited, has provided a copy of a survey conducted by a state of federal agency within the 36 months prior to application submission that contains the corrective action plan for any identified deficiencies, as well as proof of state or 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 other government health-related program.
- Is currently enrolled in and has active status with Medicare, including any sub-entities and/or additional NPI numbers the organization may utilize.

Application process

- Complete an Ancillary/Facility Credentialing Application with a signed and dated attestation.
- Sufficient additional information and explanations if any of the disclosure questions are answered “yes” on the application.
- All credentialing applications must contain the following information to be considered complete:
  - All applicable state and federal licenses (e.g., facility license, Drug Enforcement Agency certificate, CLIA certificate, pharmacy license).
  - Proof of current professional and general liability insurance, as applicable.
  - Proof of Medicare enrollment, per site, if submitting multiple locations
  - Proof of current accreditation, if accredited.

    Note: Current accreditation status is required for durable medical equipment, 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.

Organizational site surveys

As part of the initial assessment, an on-site review will be required of 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.

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 90 days to complete but can in some instances take longer. Once credentialing is completed and the applicant approved, Network Operations will notify the provider in writing of their participation effective date.

Facilities shall immediately restrict any individual health care provider under its control or supervision (i.e., any employee or subcontractor) from rendering services to customers if the provider ceases to meet the licensing or certification requirements or other professional standards required. Facilities must notify Cigna within 30 days of any changes in employees, subcontractors' and/or independent contractors' accreditation, certification, licensure, and/or registration status.

To maintain participation status, all providers are required to recredential at least every three years (every 36 months). Information obtained during the initial credentialing process will be updated and verified again, as required. Providers 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 separate attempts will be made to obtain the required information via mail, fax, email, or telephone. Providers who fail 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

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 comprises contracted primary care and specialty providers, and has the authority to approve or deny a provider's appointment status. All required credentialing information and verifications must be completed and less than 180 days old at the time of presentation to the Medical Director or the Credentialing Committee for approval.

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

Provider: New to plan and not previously credentialed	
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 credentialed	
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; however, the group practice affiliation will be amended.
Leaving a participating group practice to join a nonparticipating group practice	The provider's participation is terminated unless the nonparticipating group signs a contract with Bravo Health or Cigna. Credentialing is still valid until the recredentialing due date.

Provider Notification

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

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 provider credentialing and recredentialing information will not be disclosed to any person or any entity except with the written permission of the provider or as otherwise permitted or required by law.

Nondiscrimination in the Decision-Making Process

Cigna's credentialing program is compliant with all guidelines from the NCQA, 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, or gender identity, or due to the type of customers or procedures in which the provider specializes.

Provider Information, Rights, and Responsibilities

Access and Availability Standards for Providers

A PCP must:

- Have their primary office open to receive Cigna customers at least 20 hours per week.
- Ensure coverage is available 24 hours a day, 365 days a week.
- Be able to schedule appointments for Cigna customers at least two months in advance of the appointment.
- Arrange for coverage during absences with another Cigna Medicare Advantage network-participating provider as agreed upon in their provider agreement.

Primary care access standards	
Appointment type	**Access standard**
Urgent/emergency	Immediately
Nonurgent/nonemergency	Within one week
Routine and preventive	Within 30 business days
On-call response (after hours)	Not to exceed one hour in the event of an emergency
Waiting time in office	15 minutes or less

Specialist access standards	
Appointment type	**Access standard**
Urgent/emergency	Immediately
Nonurgent/nonemergency	Within one week
Elective	Within 30 business days
High index of suspicion of malignancy	Less than seven days
Waiting time in office	15 minutes or less

Behavioral health access standards	
Appointment type	**Access standard**
Emergency and nonlife threatening	Within six hours
Urgent/symptomatic	Within 48 hours
Routine	Within 10 business days

After-Hours Access Standards

All Cigna network-participating-providers must return telephone calls related to medical issues. Emergency calls must be returned within 60 minutes of receipt of the phone call. Nonemergency calls should be returned within a 24-hour time period. A reliable 24 hours a day, 365 days a year 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 a customer after hours.

Cigna conducts a yearly survey to monitor providers' 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 regarding appointment availability, physician accessibility, and after-hours care. In addition, calls are made after hours to ensure that all answering services and answering machines have the appropriate messaging or after-hours physician information for customers.

Please ensure that your office staff are available and trained to answer access and availability questions, and assist customers with their routine, urgent, and emergency care needs. Cigna will notify you in writing if your office failed to meet any of the access and availability standards during the survey. If a grievance is received regarding access and availability for your office, a Cigna representative will contact your office directly.

Changes in Address or Other Practice Information

Provider directory 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 the specialty or specialties 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.

CMS demographic verification requirements

CMS requires all MAOs to outreach to contracted providers on a quarterly basis to verify providers' 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.

The accuracy of our directories directly impacts our customers. We take this compliance requirement seriously and expect that you will cooperate fully with the attestation and validation process.

Cigna utilizes CAQH to outreach quarterly to network-participating providers to verify their demographic data. For all other provider types, Cigna outreaches via mail and gives instructions on how to complete the quarterly attestation process. As a participating provider you are required to comply with the outreach request and supply updated information within the allotted time frame. If we do not receive a response, you may be suppressed from our provider directory and/or be subject to 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 provider, visit the CAQH website to update and attest to your demographic information. If you are a facility or ancillary provider, submit your attestation by visiting the Provider Network Verification System web page CHSProviderDataValidation.com.

If there are changes to your location(s), phone numbers, or any other demographic information, it is important to notify us within seven days of the change. Do not wait for the quarterly update. If you are an individual provider, log in to the CAQH ProView website (CAQH.ProView.org) to make the updates. If you are a facility or ancillary provider, visit CHSProviderDataValidation.com to make the updates.

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 you must report to Cigna by contacting your Network Operations Representative or Provider Customer Service:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Providers joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions

Provider termination

When a provider is being terminated or leaving the network, Cigna is required to make good faith efforts to provide written notice at least 30-calendar days in advance to impacted customers. Impacted customers are those who are seen on a regular basis by the provider, have scheduled services with the provider, or have received treatment or a service from the provider within the past 90 calendar days.

Providers must provide advance written notice to Cigna (the time frame may vary based on a provider's network participation agreement) prior to terminating their agreement or leaving the network (due to retirement, office closure, moving out of area, etc.). Reference your participation agreement for termination notification requirements.

If you choose to leave the Cigna network, we ask that you inform your patients as early as possible to ensure a smooth transition. When possible, providers may discuss a suitable replacement PCP with their patients, who may then call Cigna Customer Service to make the change. If they do not select a new PCP, Cigna will assign a new one to them.

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 Cigna Medicare Advantage Provider Customer Service at **800.230.6138**. **Arizona providers** may call **800.627.7534**.

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

- Annual provider manual updates
- Letter
- Fax
- Email
- 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 Between Providers

- The PCP should provide the specialist with relevant clinical information regarding the customer's care.
- The specialist must provide the PCP with information about their visit with the customer in a timely manner.
- The PCP must document in the customer's medical record their review of any reports, labs, or diagnostic tests received from a specialist.
- It's good practice to obtain a release of information from the patient on the first visit. This allows you to send documents to the PCP, specialists, and behavioral health practitioners, as applicable, when the patient first enters treatment, as well as subsequent updates when there is a clinical indication and when the patient completes treatment.

Providers' Roles and Responsibilities

PCP role and responsibilities

Cigna recognizes family medicine, general practice, geriatric medicine, and internal medicine physicians as PCPs. In addition, 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 who participate in the Cigna Medicare Advantage network are listed in the region-appropriate provider directory, which is provided to customers and made available to the public via the online provider directory at MedicareProviders.Cigna.com > Online Provider Directory.

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

- Ensure they receive treatment as frequently as needed based on their condition.
- Develop an individualized treatment plan.
- Submit accurate and timely claims and encounter information for clinical care coordination.
- Comply with prior authorization and referral procedures, as applicable.
- Make referrals to appropriate Cigna-participating providers.
- Comply with Cigna quality management and utilization management programs.
- Conduct the Cigna 360 Annual Wellness Exam (360 Exam), an important benefit for Cigna Medicare Advantage customers. For more information, contact your Network Operations Representative.
- Use appropriate designated ancillary providers.
- Comply with emergency care procedures.
- Comply with Cigna access and availability standards as outlined in this manual, including for after-hours care.
- Bill Cigna using Form CMS-1500 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 is supported by proper documentation in the medical record.
- Comply with preventive screening and clinical guidelines.
- Adhere to Cigna medical record standards as outlined in this manual.

PCP right to request customer assignment to a new PCP (HMO only)

Cigna network-participating PCPs have a limited right to request a customer be assigned to a new PCP. 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.
- Disruptive, unruly, threatening, or uncooperative behavior to the extent that their actions seriously impair Cigna's or the provider's ability to render 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 or office staff.
- Nonpayment of required copayment(s) for services rendered.
- Receipt of prescription medications or health services in a quantity or manner 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.
- Steadfast refusal to comply with managed care restrictions (e.g., repeatedly using the emergency room in

combination with refusing to allow Cigna to coordinate treatment of the underlying medical condition).
- Other behavior that results in serious disruption of the customer-physician relationship.

The provider should make reasonable efforts to address the customer behavior that is having an adverse impact on the customer-physician relationship, such as through education and counseling, and if medically indicated, in coordination with appropriate specialists.

Procedure

- If the customer's behavior cannot be remedied through reasonable efforts and the PCP has determined that the customer-physician relationship has been irreparably harmed, they must complete the Physician Notice to Discharge a Customer from Panel form and submit it to their Network Operations Representative with details and documentation to support their decision. The form can be access at MedicareProviders.Cigna.com > Provider Resources: Forms and Practice Support > Physician Notice to Discharge Customer from Panel Form.
- Cigna will research the concern and document all actions taken by the provider and Cigna to remedy the situation. This may include customer education, counseling, or reassignment. A Cigna network-participating PCP cannot request customer disenrollment based on an adverse change in the customer's health status or utilization of services medically necessary for treatment of their condition.
- The physician is required to send the customer a notice informing them of their decision to terminate the customer-physician relationship. The notice must be sent to the customer at least 30 calendar days in advance of discharging a customer from a practice.
- The physician is required to continue customer care for at least 30–45 days, or longer, to allow the customer time to select or be assigned to a new PCP.
- The physician will transfer, at no cost, a copy of the customer's medical records to the new PCP, cooperate with the customer's new PCP regarding the transition of care, and provide information about the customer's care needs.
- A customer may request a change in PCP for any reason. The new PCP selected by the customer will become effective the first of the month following receipt of the request, unless circumstances require an immediate change.

Specialist role and responsibilities

Each Cigna customer is entitled to see a specialist for certain services required for treatment of a given health condition. The specialist 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 PCP 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 for after-hours care.
- Comply with prior authorization and referral process, as applicable.
- Comply with Cigna quality management and utilization management programs.
- Bill Cigna using Form CMS-1500 or electronically in accordance with Cigna's 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 is supported by proper documentation in the medical record.
- Ensure that when billing for services provided, coding is specific enough to accurately capture the acuity and complexity of a customer's condition, and supported by proper documentation in the medical record.
- Refer customers to appropriate Cigna-participating providers.
- Submit encounter information to Cigna accurately and in a timely manner.
- Adhere to Cigna medical record standards as outlined in this manual.

Medical Records

Cigna requires the following items to be in a customer's medical records:

- 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 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 network participation.

Behavioral Health

Responsibilities of the PCP

PCPs can participate in the identification and treatment of their customer's behavioral health needs. PCPs' responsibilities include:

- Screening and early identification of behavioral health and substance use disorders.
- Treating customers with behavioral health care needs within the scope of their practice and according to established clinical practice guidelines. These can be customers with comorbid physical and minor behavioral health problems, or those who require treatment but refuse to access a behavioral health or substance use disorder provider.
- Consulting with and/or making referrals for customers with complex behavioral health needs, or those not responding to treatment.
- Communicating with other physical and behavioral health providers on a regular basis.
- Submitting claims with appropriate medical and behavioral health diagnosis codes. If you have questions, go to MedicareProviders.Cigna.com > Provider Education > Documentation and Coding Resources.
- Coordinating care with the patient's behavioral health practitioner when the patient first enters treatment, as well as sending subsequent updates when there is a clinical indication and when the patient completes treatment.

Access to Care

Customers may access behavioral health services as needed.

- Customers may self-refer to any network-participating behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Customers may access their PCP to discuss their behavioral health care needs or concerns, receive treatment that is within their PCP's scope of practice, and request a referral to a behavioral health practitioner. Referrals, however, are not required to receive most network-participating behavioral health or substance use disorder services.

- Customers and providers can call Cigna Medicare Advantage Behavioral Health to receive orientation on how to access behavioral health services, provider information, and prior authorizations at **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 Diagnostic and Statistical Manual of Mental Disorders multi-axial classification system and document a complete diagnosis. The provision of behavioral health services requires progress note documentation that corresponds with the day of treatment, the development of a treatment plan, the outcome of treatment, and the discharge plan, as applicable, for the customer in treatment.

Continuity of Care for Behavioral Health

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

- Evaluate the customer if they were hospitalized for a behavioral health condition within seven 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 customers who need a follow-up visit and refer them to Cigna's behavioral health focused case management program, as necessary.
- Discuss cases, as needed, with a peer reviewer.
- Request prior authorization for a customer in an active course of treatment with a nonparticipating practitioner.

Cigna monitors the continuity and coordination of care for behavioral health customers annually through use of the following:

- Provider coordination-of-care survey – measures communication between behavioral health and PCPs, including accuracy, sufficiency, timeliness, clarity, and frequency
- Antidepressant medication-compliance rates
- Appropriate use of psychotropic medications
- Diabetes monitoring for people with diabetes and schizophrenia
- Diabetes and cardiovascular disease screening
- Monitoring for people with schizophrenia or bipolar disorder who use antipsychotic medications (individuals with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes).

Utilization Management for Behavioral Health

The Clinical Operations department is staffed by licensed health care providers and board-certified behavioral health physicians who coordinate 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.

The 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, 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 prior authorization, Cigna will approve the request or issue a notice

of denial if the request is not medically necessary. For noncovered services, Cigna will issue a notice of denial for services not covered by Medicare.

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 30 days' 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

For 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, go to MedicareProviders.Cigna.com > Pharmacy Resources.

Cigna utilizes a customized classification system defined by the Pharmacy and Therapeutics 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 CMS. The Pharmacy and Therapeutics 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:

- Dispensed only by prescription
- Approved by the FDA
- Used and sold in the U.S.
- 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.
  - 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)
- Nonprescription 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 (except when prescribed for other FDA-approved indications, such as pulmonary hypertension)

Part D Utilization Management

Cigna formularies include utilization management requirements such as prior authorization, step therapy, and quantity limits. To access the Cigna Medicare Advantage Part D utilization management requirements, go to MedicareProviders.Cigna.com > Pharmacy Resources.

Prior authorization

For certain prescription drugs, Cigna requires customers or their provider to obtain prior authorization before the prescription will be covered. This is needed to determine if a drug should be covered under the customer's Medicare Part B or Part D benefit. Another common reason prior authorization may be required is to ensure that a drug is being used for a medically accepted or Part D-allowed indication, as defined above. Some drugs may have more detailed prior authorization criteria and require submission of medical information such as lab results and current and/or past medication history.

Providers can submit prior authorization requests electronically via their electronic health record (EHR) using CoverMyMeds or Surescripts®, or by using the Surescripts website (registration required) or online forms available on the Cigna website . Go to Cigna.com > For Medicare > Member Resources > Customer Forms. If unable to use the electronic prior authorization function, Cigna Medicare Advantage Provider Customer Service can be reached by phone, fax, or mail.

Coverage determination filing

A coverage determination is any decision made by or on behalf of a Part D plan sponsor (such as Cigna) regarding payment or benefits to which a customer believes they are entitled. A coverage determination may be received orally or in writing from the customer (or appointed representative) or the customer's prescribing physician.

Coverage determination outcome notification time frames

Request type	Outcome notification method	Time frame
Standard	Phone, fax, or U.S. mail	No later than 72 hours after the initial request was received or receipt of the supporting statement
Urgent	Phone, fax, or U.S. mail	No later than 24 hours after the initial request was received or receipt of the supporting statement

Note that if the request is regarding payment for a prescription drug the customer already received, an expedited request is not permitted; customers can submit an Enrollee Prescription Drug Claim Form to request reimbursement. Cigna will provide a decision and written coverage determination notice no later than 14 calendar days from the date the request was received.

Information provided for denied and approved coverage determinations

Coverage determination	Information provided
Denied	• The specific reason for the denial, taking into account the customer's medical condition, disabilities, and special language requirements, if any • Information regarding the right to appoint a representative to file an appeal on the customer's behalf • A description of both the standard and expedited redetermination processes and time frames, including conditions for obtaining an expedited redetermination and the appeals process
Approved	• The duration of an approval • Limitations associated with an approval and any coverage rules applicable to subsequent refills.

Redetermination or appeal filing

A Part D appeal, or redetermination, must be filed within 60 calendar days from the date that appears on the coverage determination denial letter. Cigna can receive it orally or in writing from a customer, a customer's representative, or a customer's prescribing physician or other physician.

Part D appeal outcome notification time frames

Appeal type	Outcome notification method	Time frame
Standard	Phone, fax, or U.S. mail	No later than seven calendar days after the appeal was received
Expedited	Phone, fax, or U.S. mail	No later than 72 hours after the appeal was received

Expedited appeals may be requested in situations where applying the standard time frame could seriously jeopardize the customer's life, health, or ability to regain maximum function. The Request for Redetermination of Medicare Prescription Drug Denial form is available at Cigna.com > For Medicare > Member Resources > Customer Forms > Redetermination Request Forms > Medicare Part D Prescription Plans: Redetermination Form [PDF].

Note that if the request is regarding payment for a prescription drug the customer already received, an expedited appeal is not permitted and customers can submit an Enrollee Prescription Drug Claim Form to request reimbursement. Such requests must be received in writing. Cigna will provide a decision and written coverage determination notice no later than 14 calendar days from the date the request was received.

Part D appeals contact information:

- Phone: 866.845.6962
- Fax: 866.593.4482

Step therapy

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

Quantity limits

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

Pharmacy Quality Improvement

The Cigna Medicare Advantage Pharmacy Quality department maintains clinical programs that meet or exceed CMS and NCQA standards, drive improvements in CMS Star ratings and Healthcare Effectiveness Data and Information Set (HEDIS®[7]) metrics, and continually strive to improve quality of pharmacy care and prevent under- or overutilization of medication therapy among our customers. These programs include, but are not limited to:

- Medication therapy management
- Opioid drug management
- Case management pharmacy referral
- Clinic-based pharmacists
- Population health: Pharmacy and medical integration
- Drug utilization review
- Pharmacy Stars support

A description of each program is included below.

Medication therapy management program

Cigna's medication therapy management program is designed to help improve medication therapy outcomes by identifying gaps in care, addressing adherence, and recognizing potential cost-savings opportunities. It is designed for customers who satisfy certain CMS criteria.

Eligible customers are automatically enrolled into the program and sent a welcome letter encouraging them to call to complete their comprehensive medication review before their annual wellness visit. Customers who call speak with a clinical pharmacist who will review with them their prescriptions, over-the-counter medications, herbal therapies, and dietary supplements. Any potential drug therapy problems identified during the call will be sent to the prescribing provider and/or PCP by mail or fax, along with an updated list of the customer's medication history through the previous four months. The customer will also receive an individualized letter that includes their personal medication record of all medications discussed and a medication action plan.

In addition to this review, customers may also receive quarterly targeted medication reviews. These reviews are generated using the medication therapy management software to review for specific drug therapy problems. If any drug therapy programs are identified, a letter may be mailed or faxed to the prescribing provider and/or PCP.

There is no additional cost for participation in the medication therapy management program. The Medication Therapy Management Program Comprehensive Medication Review completion rate is a Part D Star rating based off the percentage of customers who meet eligibility criteria for a medication therapy management program and who receive a comprehensive medication review.

If you have patients with Cigna Medicare Advantage plans who are eligible for the medication therapy management program, please refer them by calling **800.625.9432** so that they may complete their annual comprehensive medication review. For more information, go to Cigna.com > For Medicare > Member Resources: Overview > Manage Medications: Medication Therapy Management

Opioid drug management program

Cigna's opioid drug management program is designed to identify patterns of inappropriate opioid utilization with the goal of enhancing customer safety through improved medication use. Quarterly reports are generated using an algorithm aligned with CMS criteria that identifies customers who may be potentially at risk of opioid overutilization. Customers are identified either based on their number of prescribers, number of pharmacies,

7 HEDIS is a registered trademark of NCQA.

calculated morphine milligram equivalent (MME) per day, or having a history of an opioid-related overdose and recent opioid utilization. Individuals who have active cancer-related pain or sickle cell disease, are receiving hospice or palliative care, or are a resident of a long-term care facility are excluded from the program.

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 fax written notification letters to the prescribers involved in the customer's care requesting information pertaining to the medical necessity and safety of the current opioid regimen. Cigna clinical staff may 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 Cigna. 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, multidisciplinary team according to CMS requirements.

As part of our ongoing partnership with providers to reduce unnecessary use and diversion of controlled substances, Cigna encourages prescribers and pharmacists to fully utilize their state's prescription drug monitoring program (PDMP). You can locate your state's program by going to PDMPassist.org/state.

Case management pharmacy referral programs

The Cigna Pharmacy Quality Improvement team works collaboratively with the Cigna Case Management department to provide comprehensive medications reviews for high-risk customers, including customers recently discharged from inpatient care, and/or customers with potential medication-related issues or concerns. The program is designed to help optimize medication treatment, improve medication adherence and management, and assist with medication affordability.

The team's clinical pharmacists partner with Cigna's case managers to provide recommendations for the customers. Recommendations to resolve potential drug therapy problems are also communicated to the customer's provider(s) via faxed letter.

These programs support CMS requirements for a SNP Model of Care (MOC) and NCQA standard practices for accreditation.

Clinic-based pharmacist program

Cigna's clinic-based pharmacist team partner with provider groups and independent practice associations (IPAs) that have a high volume of customers to provide customer-facing care. They drive initiatives to improve customer and plan outcomes for Cigna Medicare Advantage, and collaborate with customers and their health care team to provide support and care in a variety of environments, including face-to-face, telephonic, and virtual.

The clinic-based pharmacists support other pharmacy quality programs described in this manual, as well as additional initiatives, all of which are provided specifically for the clinic-based pharmacist's assigned customer population.

Population health: Pharmacy and medical integration program

Cigna's Population Health Pharmacy team develops and coordinates initiatives to reduce medical and pharmacy costs, improve customer health outcomes, and increase pharmacy-related quality ratings. The team employs strategies to reduce access barriers associated with medication use, and provides pertinent pharmacy benefits and services education to internal and external stakeholders, including health systems, providers, and providers' office support staff.

Drug utilization review program

Drug utilization review is a structured, ongoing review of prescribing, dispensing and use of medication to identify potential drug therapy problems that could result in adverse drug events.

Retrospective drug utilization review evaluates prescription drug claims data (after the medications have been dispensed to the customer).

Concurrent drug utilization review is typically performed at the point-of-sale, or point of distribution, by automated checks that are integrated into the pharmacy claims processing system (before the medications have been dispensed to the customer).

Cigna clinical staff tracks and trends all drug utilization review data on a monthly or quarterly basis. The types of drug therapy problems that are identified and addressed include, but are not limited to:

- Underutilization or failure to refill prescribed medications
- Drug-to-drug and drug-to-disease interactions
- Overutilization or duplicate therapy
- Narcotic safety, including potential abuse or misuse
- Use of medications classified as high risk for use in the older population

Cigna's retrospective drug utilization review is conducted through various channels. Cigna clinical staff will alert prescribers of drug therapy problems through mail, fax, or EHR integrated messaging solution (where available).

Cigna's concurrent drug utilization program aligns with CMS requirements for opioid safety edits. Safety controls will be implemented at the point of sale, including "soft" and "hard" concurrent drug utilization edits, which will reject opioid claims that meet certain utilization criteria. The dispensing pharmacy may override a "soft" rejection by entering the appropriate pharmacy professional service (PPS) codes upon consulting the prescriber and/or determining the safe and appropriate use of the medication. "Hard" rejections may not be overridden at the point of sale; to request coverage of the medication(s), a coverage determination must be initiated.

The current opioid concurrent drug utilization safety edits are listed below. They align with CMS guidance on required and recommended utilization management of opioid prescriptions.

- Opioid prescriptions are limited to a maximum of a one-month supply OR a seven-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" edit and will require a coverage determination for coverage under the customer's part D plan if a day supply exceeding these limits is needed. However, if the customer meets a specific exemption (including not being truly opioid-naïve, in palliative care, has cancer, is in long-term care, or has sickle cell anemia), the dispensing pharmacist may use PPS codes to override this "hard" rejection.
- Opioid prescriptions for customers who have claims exceeding a total of 90 MMEs per day AND have two or more opioid prescribers will receive a "soft" rejection at the point-of-sale. Coordination of care between

the prescriber and the dispensing pharmacist is encouraged. Upon consulting the prescriber and receiving approval, the dispensing pharmacist may use PPS codes to override the "soft" rejection.
- Opioid prescriptions will "soft" reject at the point-of-sale if an interaction with a benzodiazepine from a different prescriber is detected. The dispensing pharmacist may override the denial with PPS codes if they consult with the prescriber, provide customer counseling, and/or determine that it is safe to dispense the medication(s).
- Opioid prescriptions for long-acting opioid medications will "soft" reject at the point of sale if a duplication of therapy is detected between two or more long-acting opioid medications. The dispensing pharmacist may override the denial with PPS codes if they consult with the prescriber, provide customer counseling, and/or determine that it is safe to dispense the opioid medication(s).

Pharmacy Stars Support Programs

Cigna has multiple programs to specifically support pharmacy-related Medicare Part C and D Star measures:

- Statin use in persons with diabetes
- Statin therapy for patients with cardiovascular disease
- Medication adherence for diabetes medications
- Medication adherence for hypertension (RAS antagonists)
- Medication adherence for cholesterol (statins)
- Medication therapy management program completion rate for comprehensive medical review

Low-Income Subsidy Program

Overview

The federal Medicare Extra Help (or Low-Income Subsidy) program provides extra assistance with Medicare prescription drug costs for individuals who have limited income and resources. Although most customers who are eligible for Extra Help 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 customers who quality 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 and 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 HHS.

Applying for Extra Help

Individuals with limited income and resources may qualify for Extra Help to reduce their out-of-pocket costs. Applying for Extra Help is easy. Cigna customers can choose from the following options:

- Call the Social Security Administration (SSA): **800.772.1213** or **800.325.0778** (TTY); apply over the phone or request a paper application
- Apply online: SSA.gov > Medicare > Apply for Part D Extra Help
- Call PremiumAssist (provided by Human Arc): **877.236.4471**
- Visit the Centauri Health Solutions website CentauriHS.com) > Members & Patients > Eligibility & Enrollment Services: CLICK HERE to see if you qualify

If an individual does not qualify for Extra Help, state programs may be available to help pay for prescription drug costs. Cigna encourages all customers to inquire about these federal and state programs.

Pharmacy Networks

Cigna provides access to more than 63,000 network pharmacies throughout the country. This extensive network gives our customers convenient access to many pharmacies in their area to choose for their unique needs. Options range from large chain pharmacies to locally owned, independent retail pharmacies. Long-term care, home infusion, and mail order/home delivery pharmacy options are also available.

Preferred pharmacy network

There are also a large number of pharmacies in our preferred pharmacy network, including over 29,000 retail pharmacies across the United States, that offer lower copayments on most prescriptions. Large national and regional chains in this network include Walgreens, Walmart, and many grocery store pharmacies. The network also includes numerous local and independent pharmacies options.

To view the most up-to-date list of preferred pharmacies, visit Cigna.com > For Medicare > Member Resources > Overview > Pharmacy Networks. You can also link to the provider and pharmacy directories (by region). Preferred pharmacies are identified with a grey-shaded box.

Customers can choose to use a pharmacy in 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 who take multiple prescription medications.

Home delivery

One of the most important ways to improve the health of your patients 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 them to fill their prescriptions. Using preferred mail order pharmacy services may lower patient prescription costs and medication adherence – which can lead to lower health care utilization and total health care costs. Medication adherence is also associated with better health outcomes and decreased risk of hospitalization.

Express Scripts

Express Scripts® Pharmacy, a Cigna company, is the preferred home delivery pharmacy. Cigna Medicare Advantage customers should first set up an account with Express Scripts to get their current prescriptions filled through home delivery. They can do this by calling Express Scripts at **877.860.0982** or registering online at Express-Scripts.com > Register. Express Scripts will outreach to the provider for the prescriptions.

A complete listing of home delivery pharmacies can be found (MedicareProviders.Cigna.com) > Other Resources: Pharmacy Resources > Medication Adherence (select a state).

To request participation in the Express Scripts Pharmacy network, please go to ESIProvider.com.

Specialty pharmacies

Accredo

Accredo®, a Cigna specialty pharmacy, is Cigna's preferred specialty pharmacy. Accredo has a team of specialty-trained pharmacists and nurses who are available 24 hours a day, 365 days a year to help customers with questions about their specialty medications. Accredo is ready to work with you and the customer to help them receive the best possible care. To get started, call an Accredo Patient Care Advocate at **877.860.0982**.

Provider Communications and Marketing

The information below is a general guideline to assist Cigna providers who have contracted with multiple Medicare Advantage plans and accept Medicare fee-for-service customers to determine what customer outreach activities are permissible under 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 customers with enrollment decisions.

Providers can:

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

Providers *cannot*:

- Urge or steer their patients towards any specific plan or limited set of plans.
- Accept or collect Medicare scope-of-appointment or enrollment applications.
- Offer inducements to persuade customers 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 disenrolling from the health plan to encourage reenrollment 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.

Note: 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 requirements regarding provider outreach. For the most current guidelines, go to the CMS website (CMS.gov) > Medicare > Health Plans: Managed Care Marketing > Medicare Marketing Guidelines > Medicare Communications and Marketing Guidelines.

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 HSS Secretary – but absent an 1135 waiver by the HSS 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 will be posted to MedicareProviders.Cigna.com indicating the impacted state(s), counties, effective date, and expiration date.

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

- Waive referral requirements in full for Cigna Medicare Advantage covered benefits for customers in the affected counties.
- Temporarily reduce the plan-approved out-of-network cost-share to in-network cost-share amounts.
- Waive the 30-day notification requirement to customers, as long as all the changes (such as reduction of cost-share and waiving prior authorization) benefit the customer.
- Allow Part A, Part B, and supplemental Part C plan benefits to be furnished at specified nonparticipating facilities. Note that Part A and Part B benefits must be furnished at Medicare-certified facilities in compliance with 42 CFR§ 422.204(b)(3).

In addition, note that care will not require a referral or prior authorization when:

- A provider practices in an affected county or state but treating a MAPD customer visiting from an unaffected county or state and unable to leave the area.
- A provider practices in an unaffected county or state but treating an evacuated MAPD customer who resides in an affected county.

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

Customer Information, Rights, and Responsibilities

Customer Information

When a participating PCP elects to stop accepting new customers, the provider's patient panel is considered closed. If a participating PCP closes their patient panel, the decision to stop accepting new patients must be communicated to Cigna and must apply to all patients regardless of insurance coverage. Providers may not discriminate against Cigna customers by closing their patient 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, in writing, at least 30 days before the date on which the customer panel will be closed or the time frame specified in their contract.

Benefits and services

All Cigna customers receive benefits and services as defined in their Evidence of Coverage. Each month, Cigna makes available to each participating PCP a list of their active customers. The list includes the name of the plan in which the customer enrolled, along with the customer's demographic information.

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

Cigna encourages its customers to call their PCP to schedule appointments. However, if a Cigna customer calls or comes to your office for an unscheduled nonemergency appointment, please attempt to accommodate the customer and explain to them your office policy regarding appointments. If this problem persists, please contact the Cigna Medicare Advantage Provider Customer Service number listed in the Quick Reference Guide, which can be accessed at MedicareProviders.Cigna.com > Quick Reference Guide.

Excluded services

Refer to a plan's specific Explanation of Coverage or call Cigna Medicare Advantage Provider Customer Service for assistance.

Emergency services and care after-hours

An emergency is defined as the sudden onset of a medical condition with acute symptoms and the customer reasonably believes that the lack of immediate medical attention could result in:

- Permanently placing their health in jeopardy.
- Serious impairments to body functions.
- Serious or permanent dysfunction of any body organ or part.

Refer to your agreement for the full definition of emergency services.

In the event of a perceived emergency, customers have been instructed to first contact their PCP 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.

Customers 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 obtaining prior authorization for a customer's emergency care. The PCP or their designee must be available 24 hours a

day, 365 days a year to assist customers needing emergency services. The hospital may attempt to contact the PCP for direction.

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

Cigna will reimburse nonparticipating providers in accord with CMS requirements for emergency services rendered to customers if they become injured or ill while temporarily outside the plan's service area. Customers 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 services through a Cigna Medicare Advantage network-participating provider; and the customer is either temporarily not in the Cigna Medicare Advantage service area or the Cigna Medicare Advantage provider network is temporarily unavailable or inaccessible. The customer must first attempt to receive care from their PCP. Cigna will cover treatment at a participating urgent care center without a referral.

Continuing or follow-up treatments

Except when rendered by the PCP, continuing or follow-up treatments – in or out of the service area – are not covered by Cigna Medicare Advantage HMO plans 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.

Customer Rights

Cigna customers have certain rights of which participating providers must be aware.

1. **The right to be treated with dignity and respect**

   Customers 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 (treating customers unfairly) because of their race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If customers need help with communication, such as 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 wheelchair access). Customers can also call the HSS Office for Civil Rights at **800.368.1019** or **800.537.7697** (TDD), or the Office for Civil Rights in their area for assistance.

2. **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 to whom the customer has given legal authority to make decisions on their behalf) before we 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 customers 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 we protect the privacy of their health information. For

example, customers have the right to look at and obtain copies of their medical records (the provider may charge a fee for making copies), and to ask the plan's participating providers to make additions or corrections to their medical records. (If a customer asks a plan's participating provider to do this, the participating provider must review the request and determine whether the changes are appropriate).

Customers have the right to know how their health information has been given out and used for routine and nonroutine purposes. If they have questions or concerns about the 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.

3. **The right to see participating providers, get covered services, and get prescriptions filled within a reasonable period of time**

   Customers will get most or all of their health care from participating providers; that is, from physicians and other health providers that are part of Cigna's provider network. Customers have the right to choose a participating provider; Cigna will work with them to ensure they find physicians who accept new customers.

   Customers have the right to go to a women's health specialist (such as a gynecologist) without a referral (applicable to HMO plans; PPO plans do not require referrals). Refer to the Prior Authorization section of this manual for additional guidance.

   Customers have the right to timely access to their providers and to see specialists when specialty care is needed, as well as to timely access to their prescriptions at any network pharmacy. Timely access means that customers can get appointments and services within a reasonable period of time. The Evidence of Coverage explains how customers can access participating providers to get the care and services they need, as well as their rights to receive care for medical emergencies and urgent health needs.

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

   Customers 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. Customers 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. Customers have the right to be told about any risks involved in their care, told in advance if any proposed medical care or treatment is part of a research experiment, and given the choice to refuse experimental treatments.

   Customers have the right to receive a detailed explanation from Cigna if they believe that a network-participating provider has denied care that they believe they are entitled to receive or should continue to receive. In these cases, customers must request an initial decision as described in their plan's Evidence of Coverage.

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

5. **The right to make complaints**

   Customers have the right to make a complaint if they have concerns or problems related to their coverage or care. A customer or an appointed or authorized representative may file grievances, concerns, appeals, and coverage determinations; Cigna must treat them fairly and is prohibited from discriminating against

them because they filed a complaint, appeal, or coverage determination. To obtain information relative to this right, customers should call Cigna Customer Service.

6. **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. Customers have the right to an explanation from Cigna about any bills they receive for services not covered. We must tell customers, in writing, why we 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. A provider's staff should inform customers about how to file an appeal, if asked, and direct customers to review their Evidence of Coverage for more information about filing an appeal.

7. **The right to obtain information about Cigna, participating providers, drug coverage, and costs**

   Customers have the right to obtain information about Cigna plans and operations. This includes information about our financial condition, the services we provide, and participating health care providers and their qualifications. Customers have the right to know how we pay participating providers, as well as obtain information about their Part D prescription coverage, including network-participating pharmacies. To obtain any of this information, a provider's staff should direct customers to call Customer Service.

8. **The right to receive more information about customers' rights**

   Customers have the right to receive information about their rights and responsibilities. If they have questions or concerns about their rights and protections, they should be directed to call Customer Service. Customers can also:

   - Get free help and information from their State Health Insurance Assistance Program (SHIP).
   - Obtain a free copy of the Medicare & You booklet, which contains a section about their rights and protections, by calling **800.MEDICARE (800.633.4227**) 24 hours a day, 365 days a year or by visiting Medicare.gov > Basics > Forms, Publications, & Mailings > Publications > Medicare & You. (TTY users should call **877.486.2048**.)
   - View their rights and protection online by visiting Medicare.gov > Basics: Your Medicare rights.

9. **The right to take action if they think 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. For example, customers:

   - Who believe they have been treated unfairly due to their race, color, national origin, disability, age, or religion are encouraged to inform us immediately. They can also call the Office for Civil Rights in their area.
   - Can call Customer Service for any other kind of concern or problem related to their rights and protections described in this section.
   - Can also get help from 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 or withdrawing life-sustaining treatment. In accordance with guidelines established by 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 their 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 PCP or treating provider cannot, as a matter of conscience, fulfill the customer's written advance directive, they must inform the customer and Cigna. Cigna and the PCP or treating provider will arrange for a transfer of care. Participating providers may not withhold 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 for advance directives, Cigna conducts periodic customer medical record reviews to confirm that required documentation exists.

Noncovered services

Providers may only collect fees from customers for noncovered services when the customer has been provided with a standardized written organization determination denial notice from Cigna prior to the item or service being rendered to the customer, or if the customer's Evidence of Coverage clearly states the item or service is a noncovered 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 organization determination prior to obtaining the service from the provider. If coverage is denied, Cigna provides the customer with a standardized written organization determination denial notice that states the specific reasons for the denial and informs the customer of their appeal rights. In the absence of the appropriate Cigna organization determination denial notice or a clear exclusion in the Evidence of Coverage, 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 Evidence of Coverage does not explicitly state the item or service is noncovered, the provider must advise the customer to request a preservice organization determination from Cigna, or the provider can request the organization determination 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 noncovered item or service.

Providers may not issue any form or notice that advises the customer that they will be responsible for the costs associated with noncovered services unless the customer has already received the appropriate preservice organization determination denial notice from Cigna, or the service or item is explicitly stated as a noncovered service in the Evidence of Coverage. Providers cannot hold a customer financially liable for services or supplies that are not explicitly stated as noncovered in the customer's Evidence of Coverage.

Customer Responsibilities

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

Customers are responsible for:

- Becoming familiar with their Cigna coverage and the rules they must follow to get care as a customer. They can use their Cigna Evidence of Coverage and other information we provide them to learn about their coverage, what we have to pay, and the rules they need to follow. They should call Customer Service if they have any questions or complaints.
- Knowing which providers are part of our network because, with limited exceptions, they can contact Customer Service at **800.668.3813** for assistance in finding a participating provider.

- Advising Cigna and their providers if they have other health insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that they have Cigna Medicare Advantage plan coverage and presenting their ID card to the provider, when possible.
- Giving their doctors and other providers the information needed to provide care for them, and following agreed-upon treatment plans and instructions. Customers are encouraged to ask questions they have of their doctors and other providers.
- Paying their plan premiums and any copayments or coinsurances they may have for the covered services they receive. They must also meet their other financial responsibilities as described in their Evidence of Coverage.
- Informing Cigna if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage, or Cigna operations.
- Notifying Cigna Customer Service and their providers of any address or phone number changes as soon as possible.
- Using their Cigna plan only to access services, medications, and other benefits for themselves.

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 functions 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.
- The local Cigna provider representative should be contacted for detailed information about delegation.
- The authority to perform a function can be delegated by Cigna, but the responsibility to perform a function cannot be delegated by Cigna.
- Delegated providers must comply with the responsibilities outlined in their Delegated Services Agreement and Cigna policies and procedures.
- Credentialing delegates must submit semiannual reports via email to CredDelegation@Cigna.com.

Accreditation

NCQA

Nondiscrimination and cultural competency

Participating providers shall provide health care services to all customers consistent with the benefits covered in their benefit plan, 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 that 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, and TTY 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 customers. If these services are not available in their office location, providers can call the appropriate Provider Customer Service number below to assist with translator and TTY services:

- All providers *(except in Arizona*): **800.230.6138**
- Arizona providers: **800.627.7534**.

Additional provider rights and responsibilities

Providers have rights and responsibilities in addition to those outlined in their agreement with Cigna.

Provider rights

You have the right to:

- Give feedback and suggestions on how service may be improved within Cigna.
- Request to have a customer removed from your care if an acceptable customer-provider relationship cannot be established with a customer who selected you as their PCP.
- Request claims reconsiderations for any claims you believe were not paid according to payment policy.
- Request an appeal for any claims you believe were not paid in alignment with the level of care rendered or clinical practice guidelines.
- Request to discuss any referral or prior authorization request with the Medical Director or Chief Medical Officer at various times in the review process.

Provider responsibilities

PCPs are responsible for:

- Using best efforts to provide care to new customers within four months of their enrollment with Cigna.
- Using best efforts to provide follow-up care to customers who have been in the hospital setting, within 10 days of hospital discharge.
- Coordinating routine preventive care for customers with HMO plan coverage, along with any ancillary services that need to be rendered with prior authorization.

Specialists are responsible for:

- Coordinating the referral process (including obtaining prior authorizations) for further care they recommend for customers with HMO plan coverage. *This responsibility does not revert to the PCP while the care of the customer is under the direction of the specialist.*
- Providing continuous access to care for Cigna customers 24 hours a day, 365 days a year.

All providers are responsible for:

- Treating Cigna customers the same as all other customers in their practice, regardless of the type or amount of reimbursement.
- Providing continuous access to care for Cigna customers 24 hours a day, 365 days a year.
- Coding 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.

- Arranging for another provider to render services on their behalf in the event they are temporarily unavailable or unable to provide customer care or referral services for a Cigna customer. This coverage cannot be provided by an emergency room.
- Providing continuity of care upon network termination in accordance with their contract.
- Utilizing Cigna's participating providers and facilities, for customers with HMO plan coverage, when their services are available and can meet customers' needs. Approval prior to making referrals outside of the Cigna provider network may be required.
- Participating in Cigna's peer-review activities as they relate to the quality management and utilization review programs.
- Cooperating with Cigna's quality improvement (QI) activities to improve the quality of care and services, as well as customers' experience. This includes the submission of data requested by Cigna and participation in Cigna's QI programs.
- Allowing Cigna to use their performance data, including the collection, evaluation, and use of data for QI activities.
- Maintaining customer information and records in a confidential and secure manner.
- Freely and openly discussing with customers all available treatment options, regardless of whether the services may be covered services under the customer's benefit plan, including medication treatment options, regardless of benefit limitations.
- Not balance billing for rendering Cigna-covered services. This excludes the collection of standard copayments. 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 Procedures section of this manual.
- Submitting all claims within the time frame specified in your contract.

HEDIS

HEDIS is developed and maintained by 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 and encounters), supplemental data (EMR and vendor data), and 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 contracted with CMS. A portion of measures are designated as "hybrid" and plans are allowed to collect medical record data for the prior measure year during its annual medical record review. The record collections process typically runs from the end of January until the first week in May. Each spring, Cigna representatives collect records from provider offices as part of this process and to establish final HEDIS scores.

Selected provider 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 HIPAA privacy rules. Only the minimum necessary amount of information is requested, and it is used solely for the purpose of the HEDIS initiative. HEDIS records collection 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 by emailing the Cigna Medicare Advantage QI department at FAX-SOL@HealthSpring.com

Quality Management

Cigna continually monitors its QI program and makes changes, as needed, to its structure, content, methods, and staffing. Changes to the program are accompanied by policy and procedure revisions, as well as staff training, as required. The program operates under the umbrella of the Corporate Quality Improvement Committee, which reports to the Cigna Quality Management governing body, and is reviewed and updated annually in collaboration with the QI department. Cigna's National Physician Advisory Committee, which is made up of network providers, also reviews the program and its clinical practice guidelines at certain intervals and offers improvement recommendations.

Quality Improvement Program

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

The Cigna Medicare Advantage 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.

Corporate Quality Improvement Committee

This committee has oversight authority for QI activities across the organization and is responsible for ensuring the development and implementation of Cigna Medicare Advantage QI program initiatives, annual QI and utilization management updates, and care management work plans, as well as reviewing and approving health service policies, monitoring credentialing, providing delegation oversight and customer appeal activity, and reviewing clinical and service quality initiatives.

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

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 – We recognize that employees are our main asset and encourage their 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 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 Advantage and through our provider partners.
- Promote customer safety as an overriding consideration in decision making.

The Quality Improvement program provides guidance for the management and coordination of all quality improvement and quality management activities throughout the Cigna Medicare Advantage organization, its affiliates, and delegated entities. It continuously monitors, evaluates, and strives to improve the clinical care and services provided to Cigna customers relating to both their physical and behavioral health. The program also defines the health plan's methodology for identifying improvement opportunities as well as for developing and implementing initiatives to impact the identified opportunities.

Special Needs Plans

In 2008, CMS issued the final regulation Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). This regulation mandates that all SNPs have a filed and approved model of care (MOC) by January 1, 2010. The Patient Protection and Affordable Care Act reinforced the importance of the SNP MOC as a fundamental component by requiring NCQA review and approval.

SNP Eligibility Criteria

SNPs are designed for specific groups of customers with special health care needs. Only customers who meet the CMS criteria for the SNP types listed below may enroll in a SNP plan.

- Dual eligible SNP (D-SNP): For customers who are eligible for Medicaid and Medicare
- Chronic condition SNP (C-SNP): For customers with chronic conditions
- Institutional SNP (I-SNP): For customers who reside in a long-term care facility

CMS mandates that each of these SNP types have a MOC. The MOC is an evidenced-based care management program that facilitates early and ongoing assessments, and identifies health risks and major changes in the health status of SNP customers. It provides structure and describes the coordination of care, 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:

SNP population – the unique characteristics of the overall most vulnerable SNP customers.

Care coordination – the SNP staff structure, health risk assessment, face-to-face encounter, individualized care plan, interdisciplinary care team, and care-transition process, which are used to identify the services and benefits offered through the plan and are available to our SNP customers. The wide range of services is targeted to help SNP customers achieve their optimal health and improve their connection to care.

Provider network – Providers with specialized expertise correspond to the target population in our SNP program, collaborate with the interdisciplinary care team, and contribute to a customer's individualized care plan. Participating providers use evidence-based medicine, when appropriate, and care-transition protocols. See the SNP MOC Training section of this manual.

MOC quality measurement and performance improvement – This section of the MOC includes clinical and customer satisfaction goals, as well as the ongoing performance evaluation of the SNP MOC.

SNP MOC Training

CMS (Medicare) mandates the completion of initial and annual SNP MOC training for staff and providers, as well as documentation to reflect that training was completed. To participate in the training and to attest to it, access the appropriate link below, which will depend on the date you began your Cigna network participation.

Training description	Providers should take this course if their Cigna Medicare Advantage network participation began:	To access the training, go to:
2022 SNP MOC Training	Prior to January 1, 2023	Campaigns.Cigna.com/SNP-MOC
2022 SNP MOC Training	On or after January 1, 2023	Campaigns.Cigna.com/SNP-MOC/?source=newprovider

SNP MOC Process

The Cigna SNP MOC care management process focuses on the unique needs of SNP customers. The goal is to identify the need for interventions, care coordination, and care transitions, as well as identify barriers to care, and to provide 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, such as:

- **Health risk assessment.** To identify care needs, Cigna conducts health risk assessments of SNP customers within 90 days of their enrollment, and then annually within 365 days of their last health risk assessment.
- **Face-to-face encounter.** A face-to-face encounter must occur, as feasible and with the SNP customer's consent, at least annually beginning within the first 12 months of enrollment. The encounter must be between the SNP customer and a member of their interdisciplinary care team, as well as Cigna case management and coordination staff or participating health care providers. The encounter must either be in person or through a visual, real-time interactive telehealth visit.
- **Individualized Care Plan.** Health risk assessment results and evidence-based clinical protocols are utilized to develop an individualized care plan. The Cigna Care Management team is responsible for its development.
- **Interdisciplinary Care Team.** This team comprises the SNP customer, care managers, the PCP, and other providers or support personnel involved in the customers' care. They assist in coordinating care and services, which includes reviewing the individualized care plan. Other providers may be included on the team from various disciplines and specialties, including community resource providers, based on the customer's individual needs.
- **Face-to-face encounter.** A face-to-face encounter must occur, as feasible and with the SNP customer's consent, at least annually beginning within the first 12 months of enrollment. The encounter must be between the SNP customer and a member of their interdisciplinary care team, as well as Cigna case management and coordination staff or participating health care providers. The encounter must either be in person or through a visual, real-time interactive telehealth visit.
- **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 SNP customers.

As a provider, your participation is required for the coordination of care, care plan management, and identification of additional health care needs for SNP customers.

Cigna utilizes risk-stratification methodologies to identify the most vulnerable SNP customers, such as those who are frail or disabled, have multiple chronic illnesses, or are at the end of life. The risk-stratification process includes input from the provider, customer, and data analysis.

SNP Interdisciplinary Care Team

Cigna will invite you to participate in an interdisciplinary care team meeting when you have a patient who is an SNP customer requiring care management. We encourage you to participate in the meeting, and to collaborate in the care planning and identification of care planning goals for the SNP customer.

The Cigna SNP MOC is geared toward supporting customers and their providers with timely and continued communication during transitions of care, such as from a hospital to a skilled nursing facility or home, whether planned or unplanned. A Cigna Care Manager ensures that care is coordinated across the inpatient and/or post-acute settings, and that a safe and appropriate discharge plan is executed. This includes communicating with the customer, the caregiver, the facility, and the PCP. A PCP's involvement as a part of their patient's interdisciplinary care team is a critical aspect of the transition-of-care protocols.

If a provider wants to discuss (or request a copy of) a SNP customer's care plan, or refer a SNP customer to or participate in an interdisciplinary care team meeting, they should call the Population Health Operations intake line at **866.383.0518**.

SNP health risk assessment contact information

When a SNP customer completes a health risk assessment, it can be utilized to develop a care plan with the customer. A copy of the assessment can be obtained by calling our Health Risk Assessment department at **800.331.6769.** The customer and their assigned PCP will receive a copy of the customer's care plan based on the health risk assessment responses.

SNP scope

The SNP encompasses:

- 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 and its contracted providers and organizations.
- All aspects of provider performance relating to access to care and quality of care, including provider credentialing, confidentiality, medical record keeping, and fiscal and billing activities.
- All covered services, including assuring services are rendered in a culturally and linguistically appropriate manner.
- All professional and institutional care in all settings including hospitals, skilled nursing facilities, outpatient facilities, and at home.
- All providers and any delegated or subcontracted providers.
- Management of behavioral health care and substance use disorder care and services.
- Aspects of Cigna Medicare Advantage internal administrative processes that are related to service and quality of care, including credentialing, QI, 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.
- All SNP MOC activities.

Goals

The primary objective of the QI program is to promote and build quality into the organizational structure and processes to meet our mission of improving the health of the communities we serve by delivering quality and cost-effective health care benefits and services. The goals we have established to meet this objective include:

- Fostering communication across the enterprise.
- Collaboratively working toward the achievement of established goals.

- Monitoring progress of improvement efforts to meet established goals.
- Providing the necessary oversight and leadership reporting.
- Ensuring customer care and service are provided according to established goals and metrics.
- Ensuring the identification and analysis of opportunities for improvement, with implementation of actions and follow up as needed.
- Promoting consistency in QI program activities.
- Ensuring the QI program is sufficiently separate from fiscal and administrative management to prevent any undue influence decision-making regarding organizational determinations and/or appeals of adverse determinations of covered benefits.
- Assuring timely access to and availability of safe and appropriate physical and behavioral health services for the population served by Cigna.
- Ensuring services are provided by qualified individuals and organizations, including those with the qualifications and experience appropriate to service customers with special needs.
- Promoting the use of evidence-based practices and care guidelines.
- Improving the ability of all Cigna Medicare Advantage staff to apply quality methodology through a program of education, training, and mentoring.
- Maintaining a rigorous delegation oversight process.
- Ensuring program relevancy through an understanding of customer demographics and epidemiological data, and providing services and interventions that address the diverse cultural, ethnic, racial, linguistic, and other unique needs of customers.
- Maintaining a clinical risk management and patient safety program that includes the documentation of quality of care, adverse and never events, critical incidents, and safety issues as described in the quality of care and clinical risk management patient safety component of this QI program.
- Ensuring adequate infrastructure and resources to support the QI program.
- Assuring provider involvement in maintaining and improving the health of Cigna Medicare Advantage customers through a comprehensive provider partnership.
- Maintaining and monitoring a MOC designed for Cigna Medicare Advantage SNP customers.
- Promoting population health management strategies and activities to ensure holistic care for Cigna Medicare Advantage customers.

Compliance and Ethics

Cigna's Corporate Compliance Program

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 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. Noncompliance with regulatory standards undermines Cigna's business reputation and credibility with federal and state governments, subcontractors, pharmacies, providers, and most important, its customers. Cigna and its employees are also committed to meeting all contractual obligations set forth in Cigna's contracts with CMS. These contracts allow Cigna to offer Medicare Advantage and Medicare Part D products and services to Medicare customers.

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 Medicare Drug Integrity Contractors, 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, Medicare Drug Integrity Contractors, or law enforcement or their designees.

To report suspected or detected Cigna Medicare Advantage plan noncompliance, please contact:

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 Network Operations Representative.

Fraud, Waste, and Abuse

Cigna goes to great lengths to ensure that our 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.

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 or facts 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 or for drugs not actually dispensed
- Falsifying a 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 noncovered 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 referrals

The Special Investigations Unit is responsible for minimizing Cigna's risk of health care fraud. This unit partners with Cigna's key internal matrix partners and others to help identify suspicious claims, stop payments to fraudulent providers, and punish wrongdoers.

The Special Investigations Unit 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, and abuse, please contact Cigna's Special Investigations Unit at:

Mail:
Cigna Special Investigations
900 Cottage Grove Road
W3SIU
Hartford, CT 06152

Phone: 800.667.7145
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 analyses of all levels of CPT, ICD-10, and HCPCS codes billed by participating providers. These analyses allow us to comply with regulatory requirements for the prevention of fraud, waste, and abuse, and to supply participating providers with useful information to meet their own compliance needs in this area.

Cigna will review providers' coding and may review medical records of those who continue to show significant variance from their peers. We strive to ensure compliance and enhance the quality of claims data, benefitting our medical management efforts and the 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 fraud, waste, and abuse obligations

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

To access education resources about how to avoid common coverage, coding, and billing errors, go to CMS.gov > Outreach & Education > Medicare program > Medicare Learning Network® (MLN) Homepage > Provider Compliance.

Web-based training course:

- Combatting Medicare Parts C and D Fraud, Waste, and
- Medicare Fraud & Abuse: Prevent, Detect, Report

Cigna Medicare Advantage Program Requirements

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 and Internal Audits and Inspections

Provider shall permit the 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 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”). The Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.

Unless agreed upon otherwise by Cigna, the Provider shall have 60 days to produce 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. In such a case, the Provider shall have the right to appeal any such denial on a claim-by-claim basis.

For internal audits, Cigna requires:

- Providers to produce records at Cigna or designee request within 60 days.
- Remediation steps from audit determinations to include, but not limited to, training, recoupment, and data clean up.
- When Providers fail to comply with records requests, their claims may be deemed unsupported, and we can bring breach of contract against the claims.
- The option to recoup from Providers for retractions.

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 HIPAA.

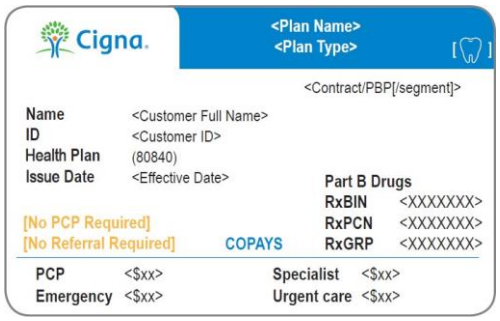
Patient Hold Harmless

Participating providers are prohibited from balance billing Cigna customers including, but not limited to, situations involving nonpayment 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 noncovered services if the Provider complies with the requirements of the noncovered services section of the Provider Manual.

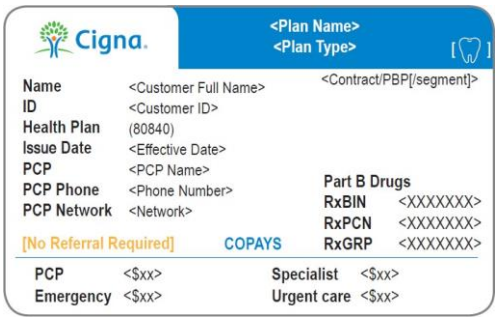
Appendix

2023 Customer ID Cards

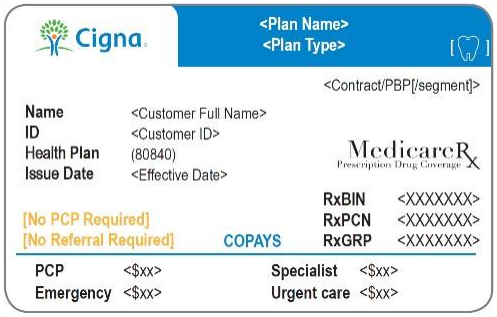
PPO: Cigna Medicare Advantage



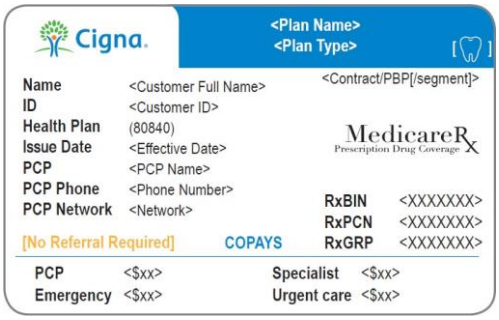
HMO: Cigna Medicare Advantage[8]



PPO: Cigna Medicare Advantage Prescription Drug



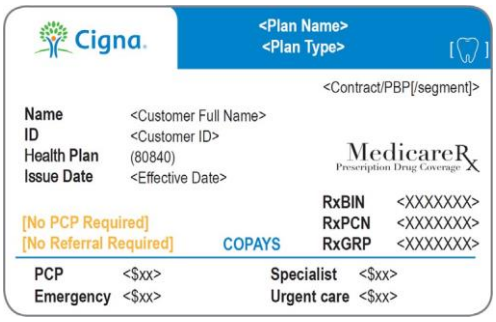
HMO: Cigna Medicare Advantage Prescription Drug[8]



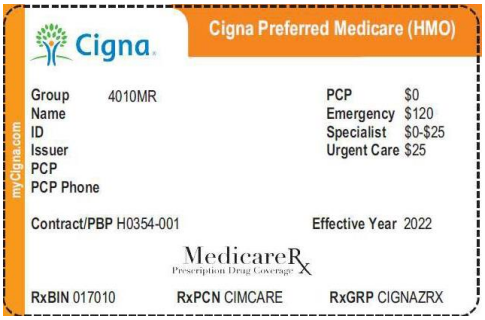
8 This sample ID card is for customers with an HMO plan that does not require referrals. IDs card for customers with an HMO plan that requires referrals will not show "[No Referral Required]."

2023 Customer ID Cards: Arizona

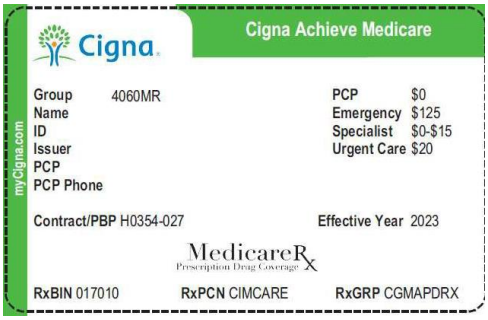
PPO:
Cigna Medicare Advantage



HMO:
Cigna Preferred Medicare



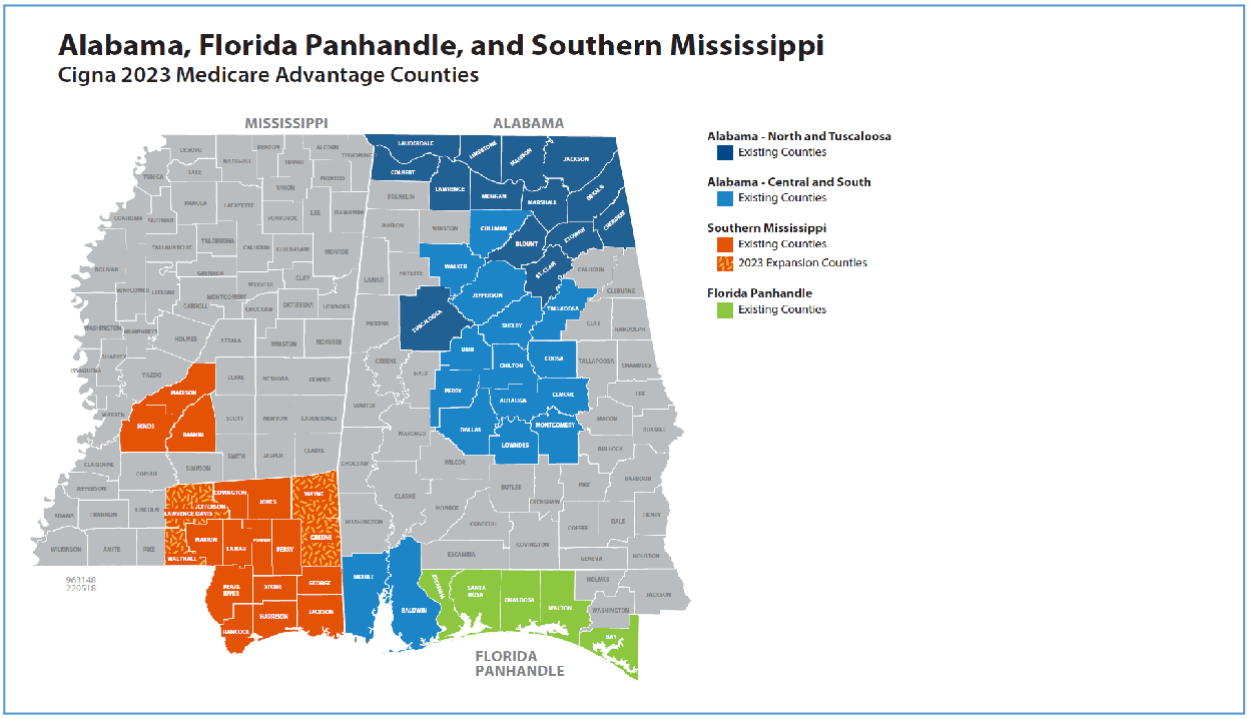
HMO C-SNP:
Cigna Achieve Medicare



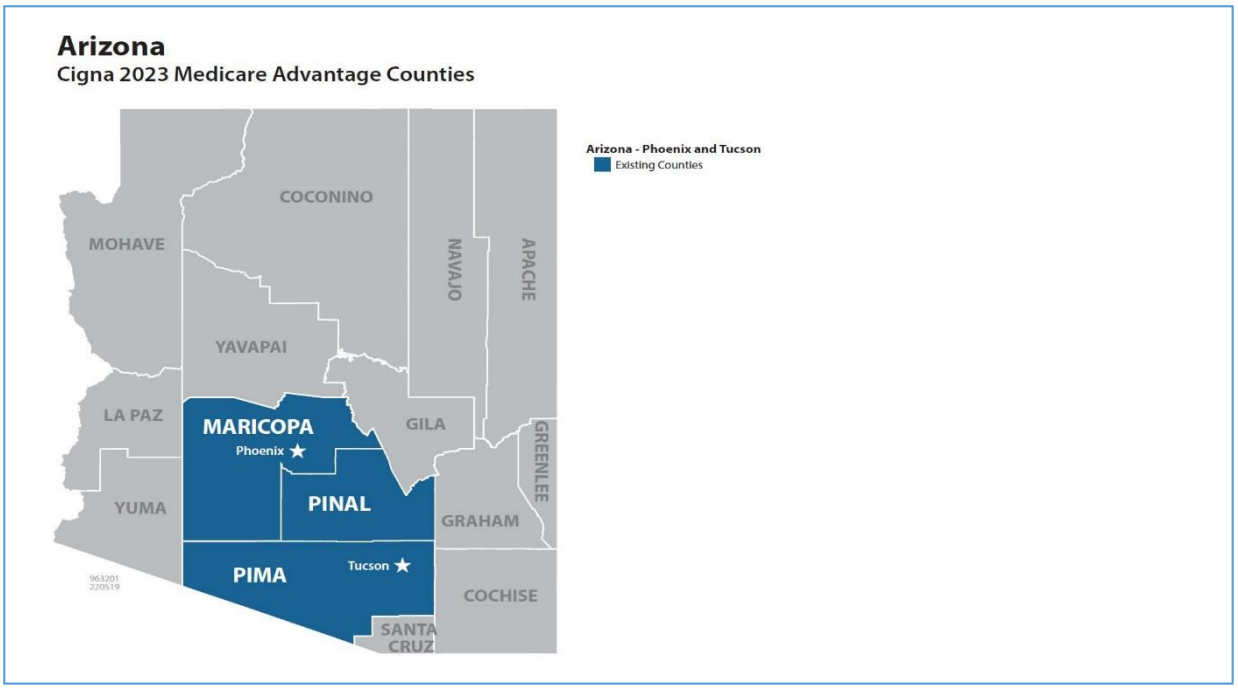
HMO:
Cigna Alliance Medicare

Service Area Maps

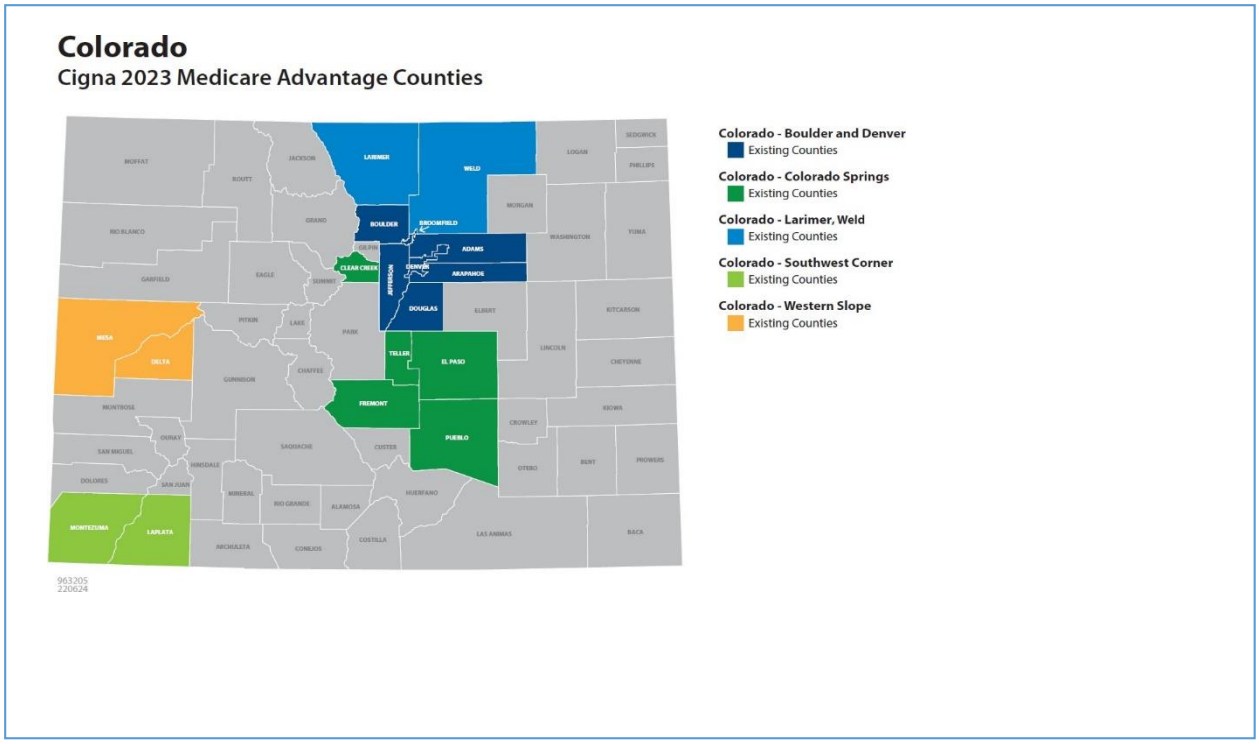
Alabama, Florida Panhandle, and South Mississippi



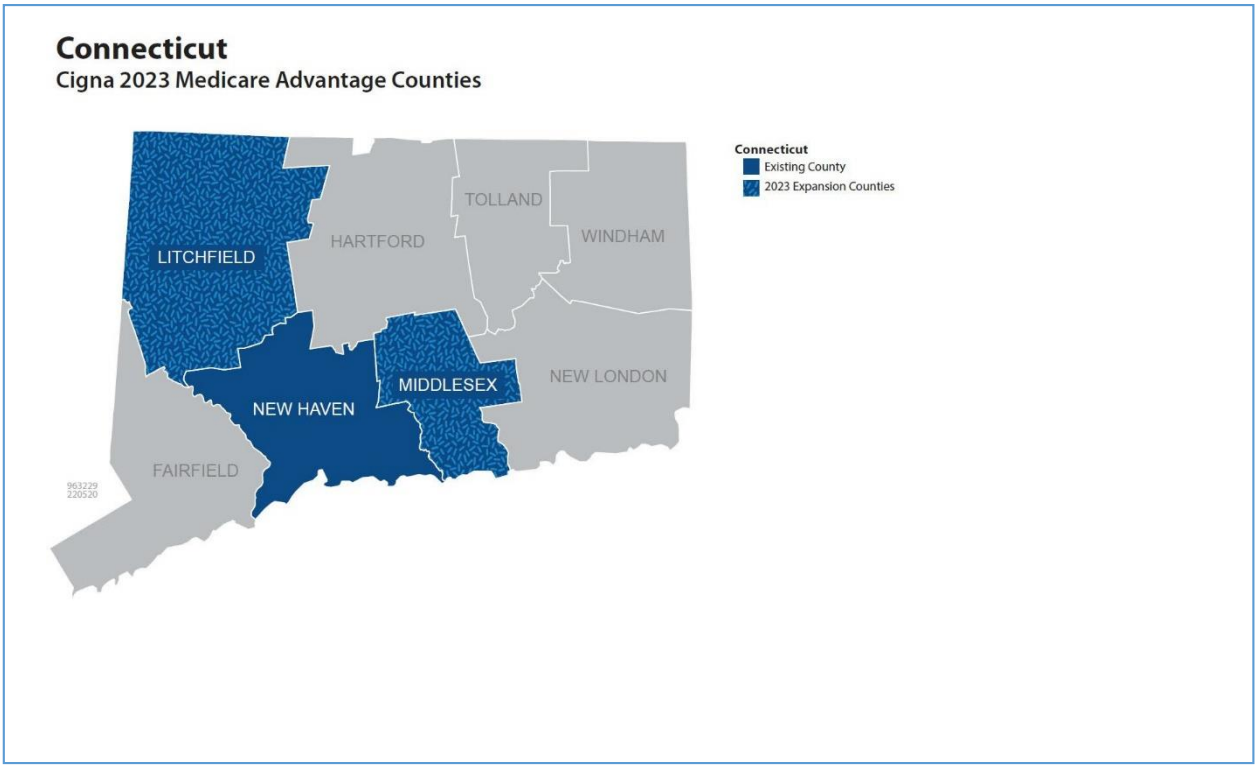
Arizona



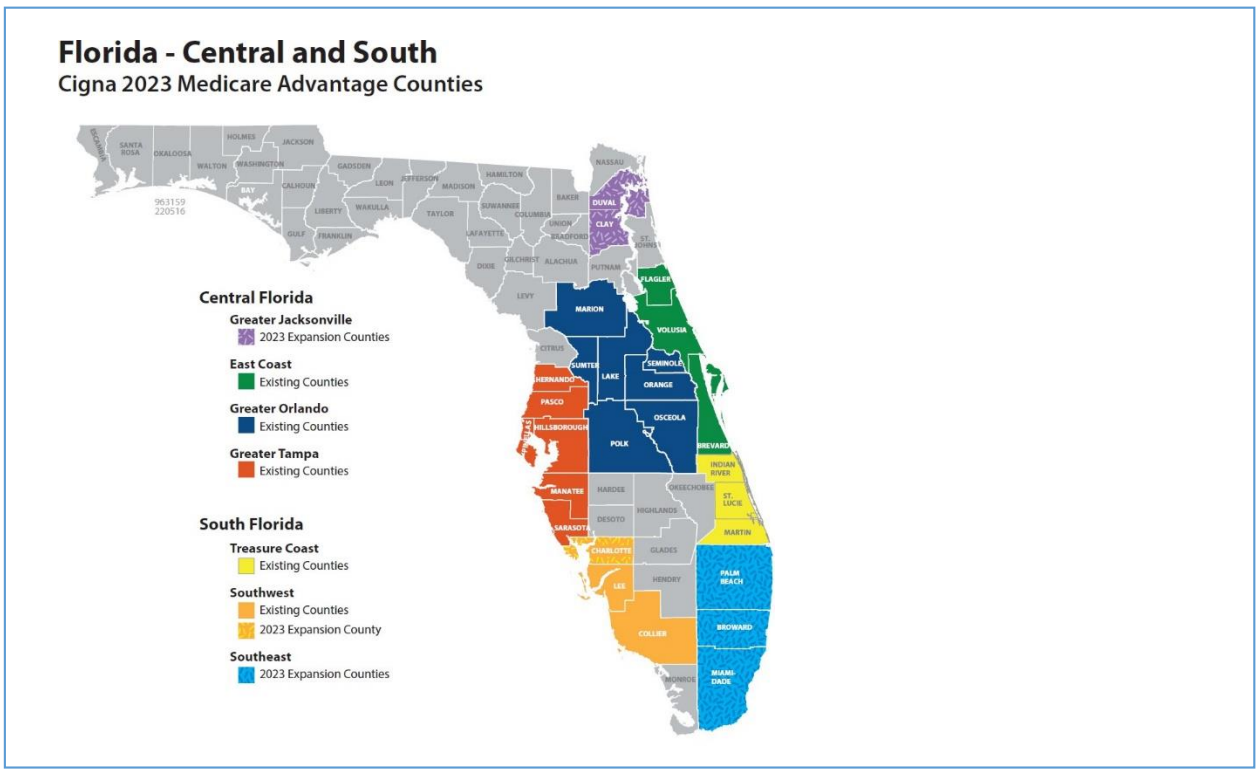
Colorado



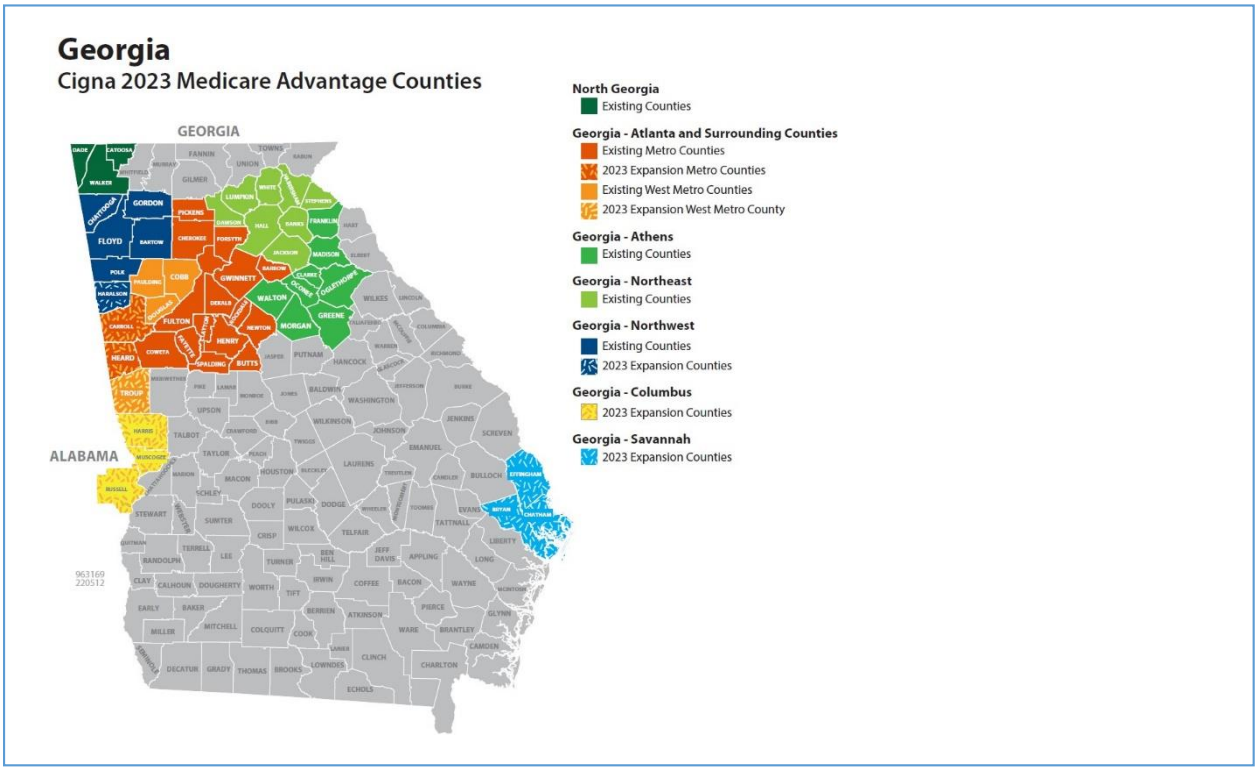
Connecticut



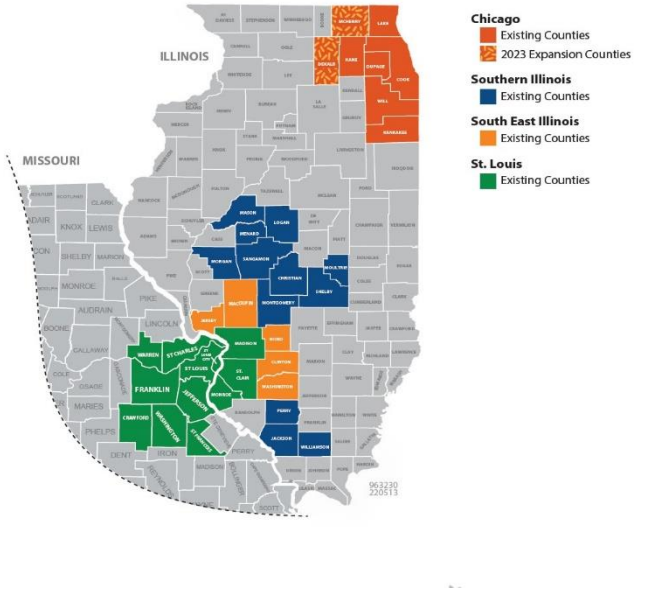
Florida



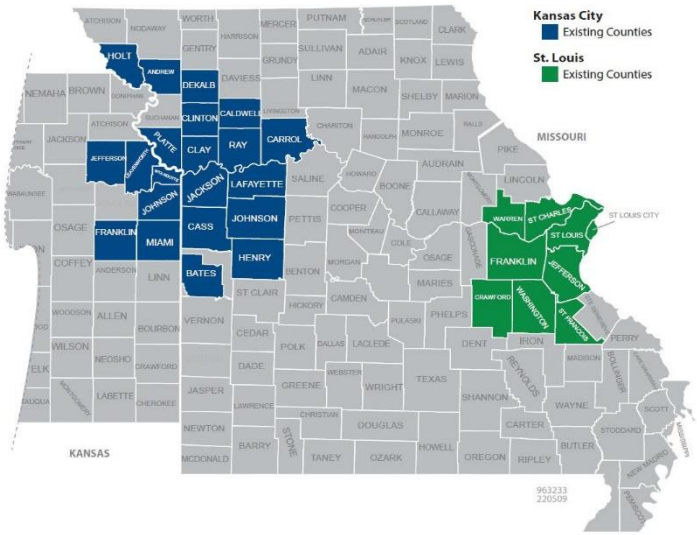
Georgia



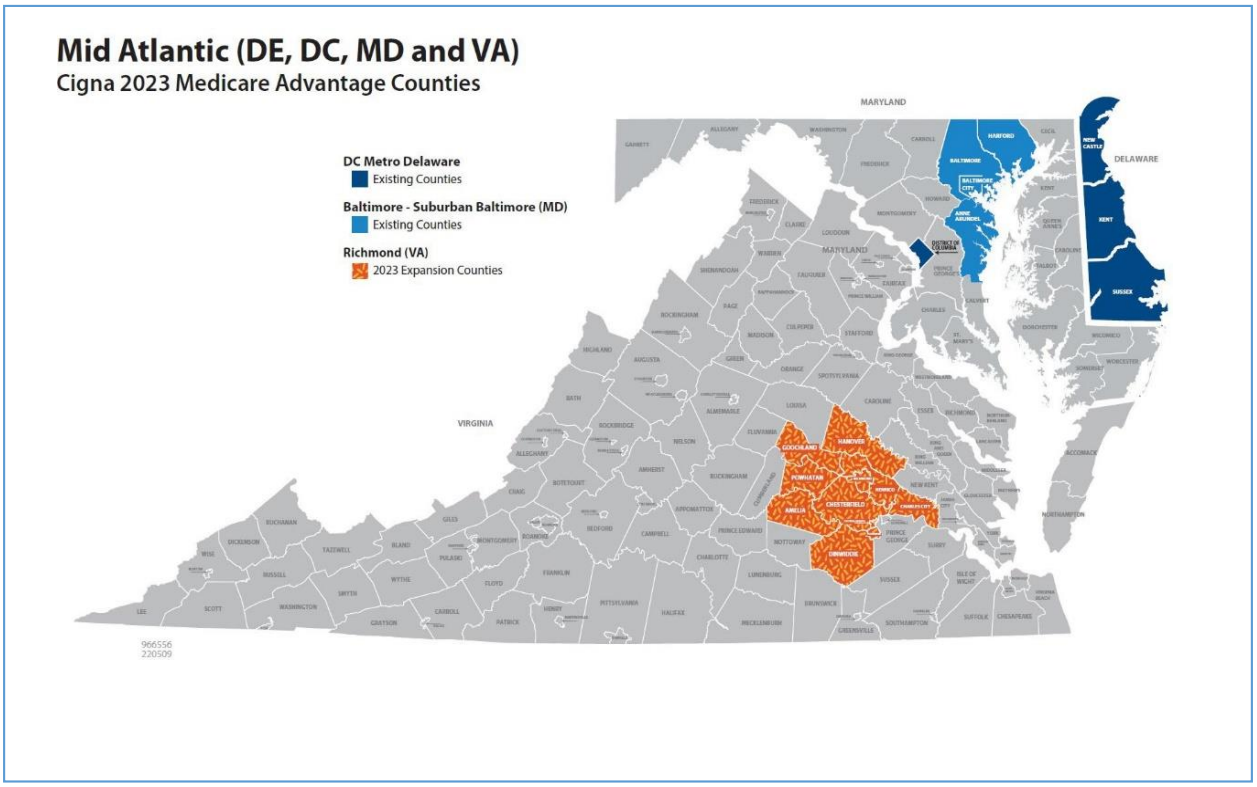
Illinois and St. Louis



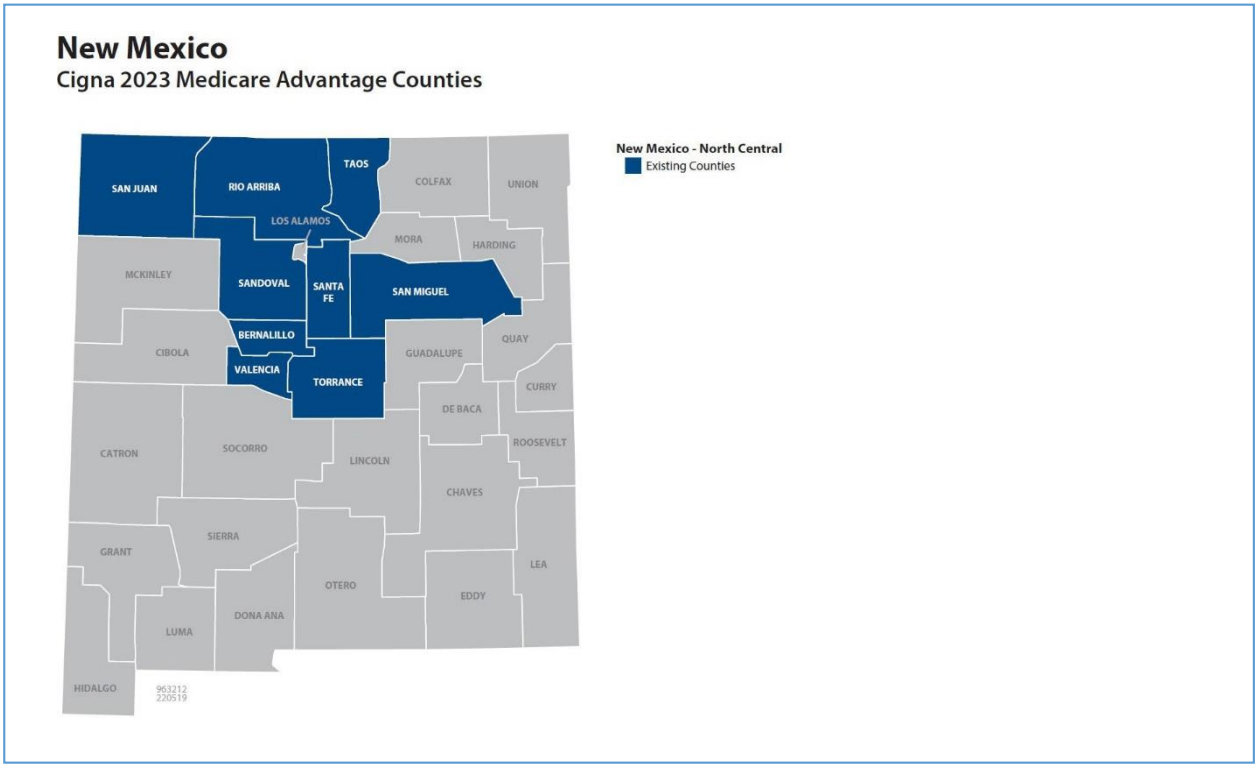
Kansas City and St. Louis



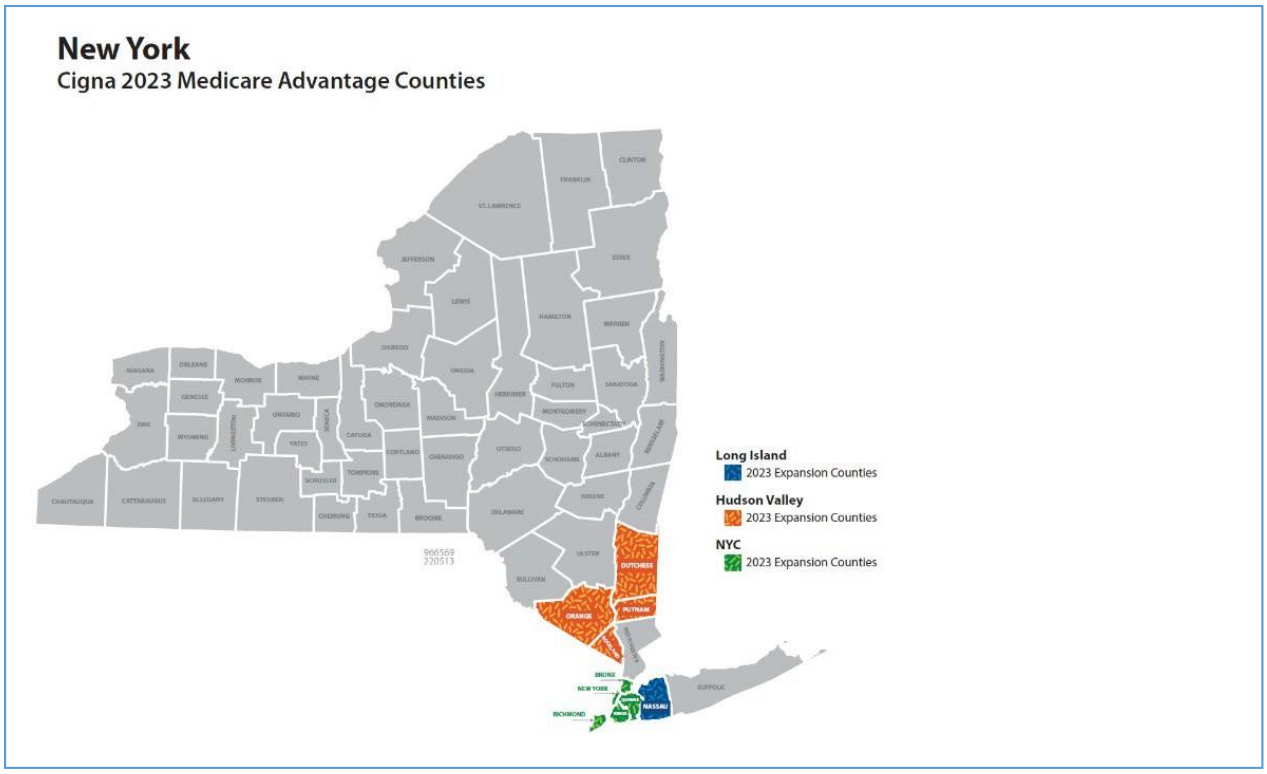
Maryland, Delaware, Washington D.C., and Virginia



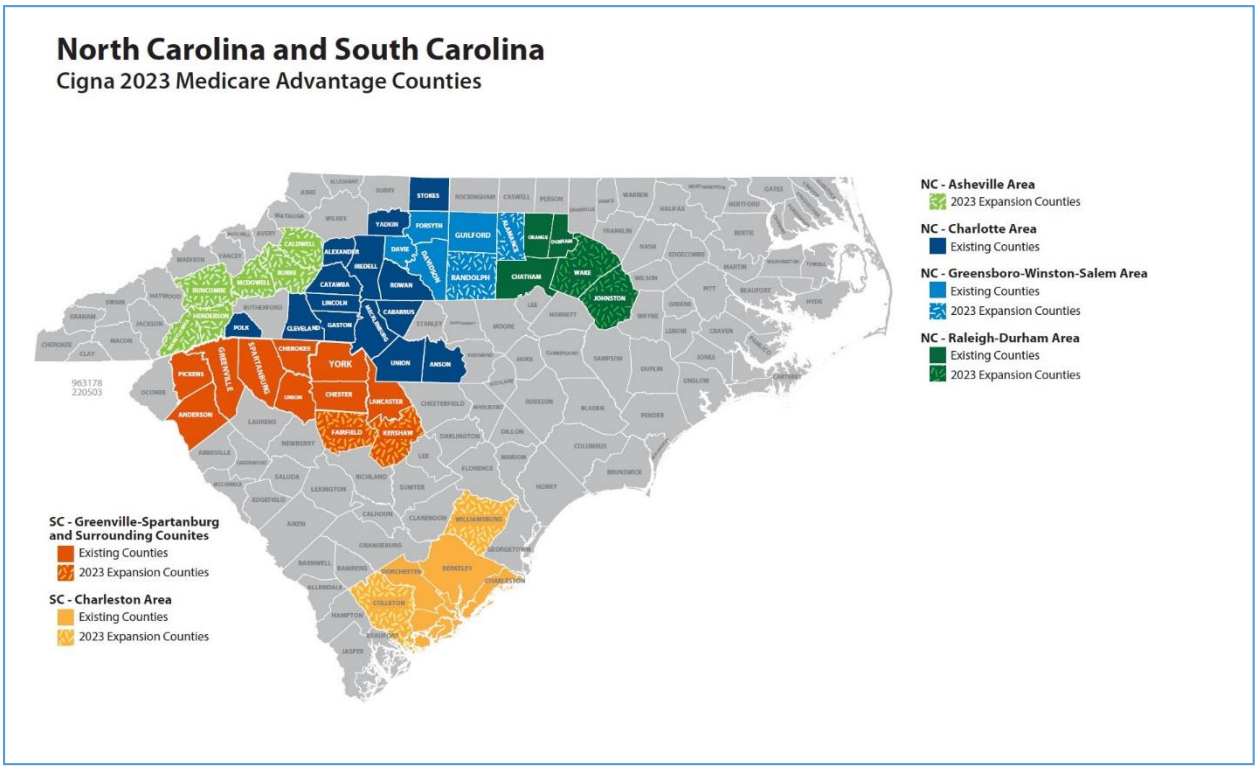
New Mexico



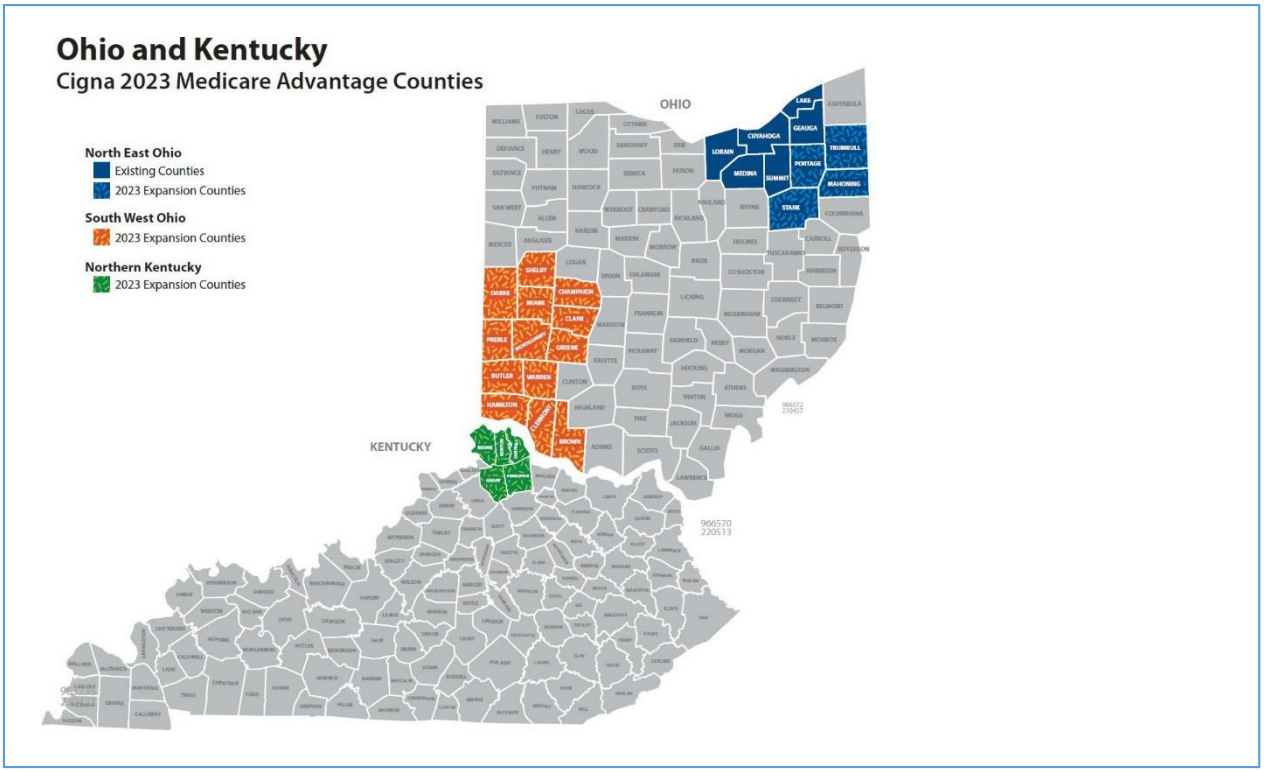
New York



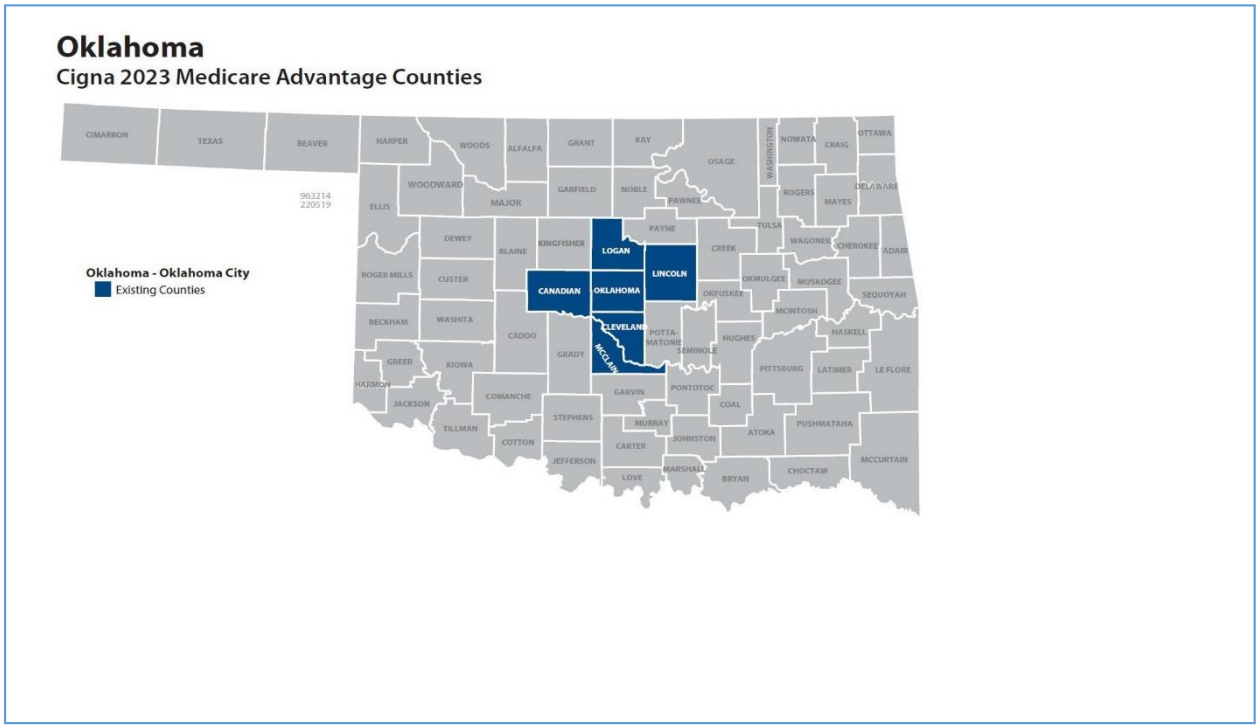
North Carolina and South Carolina



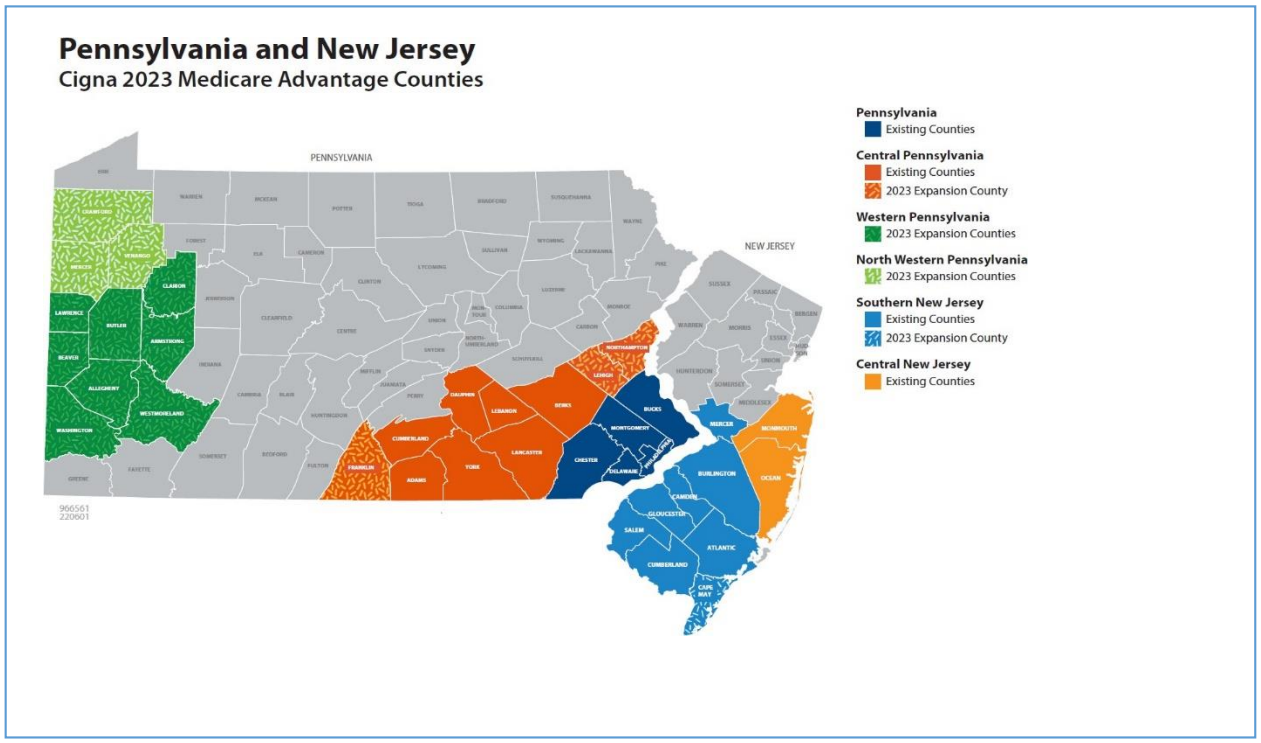
Ohio and Kentucky



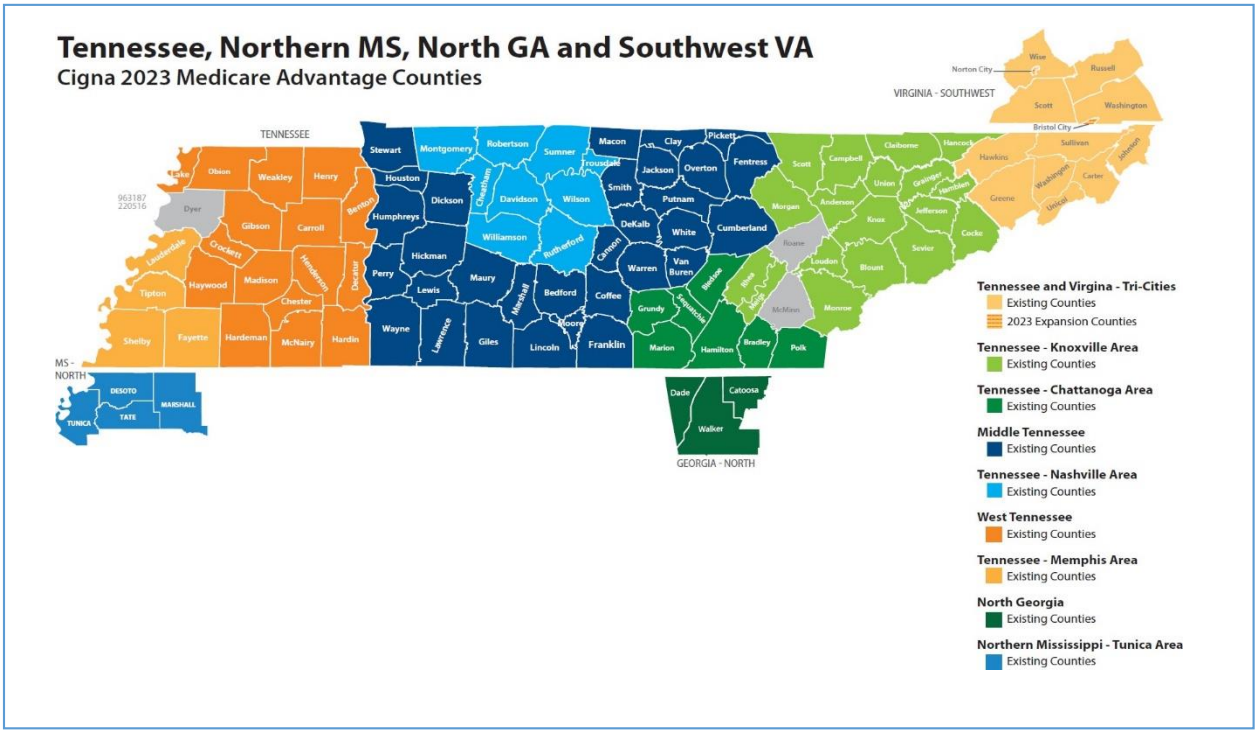
Oklahoma



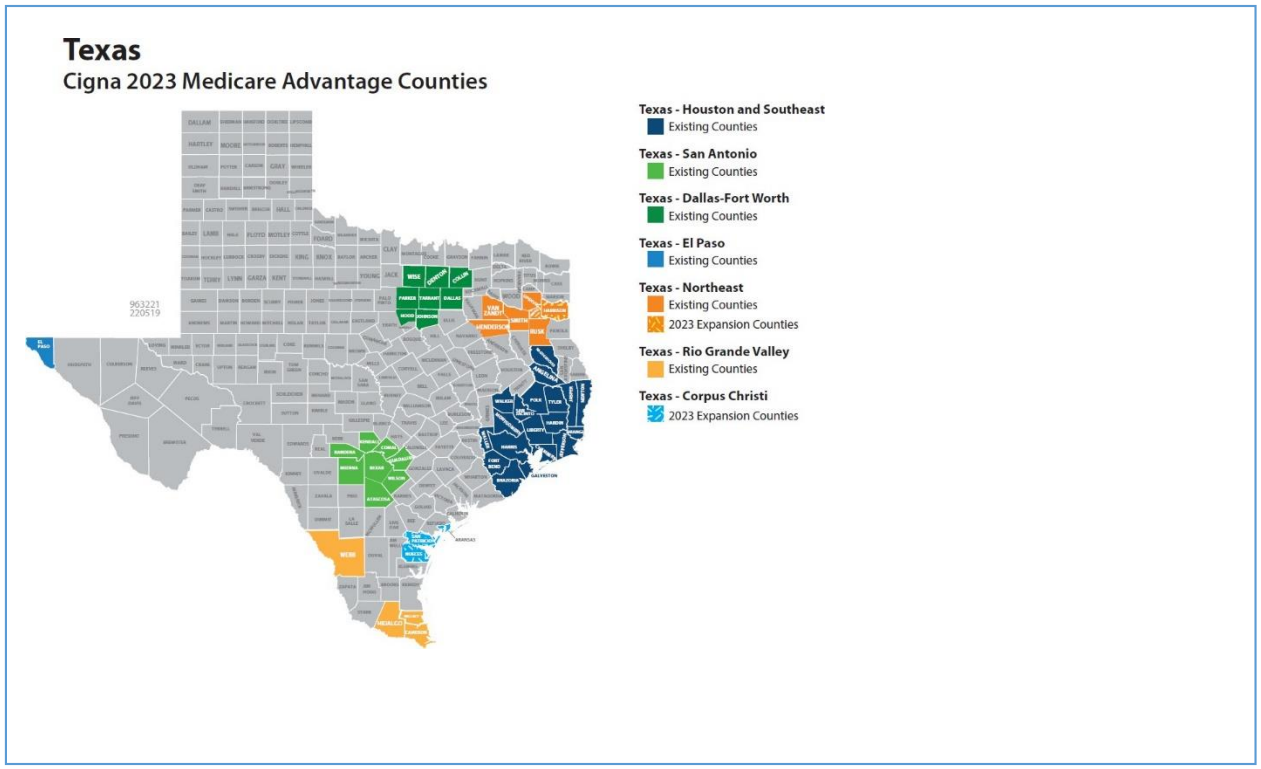
Pennsylvania and New Jersey



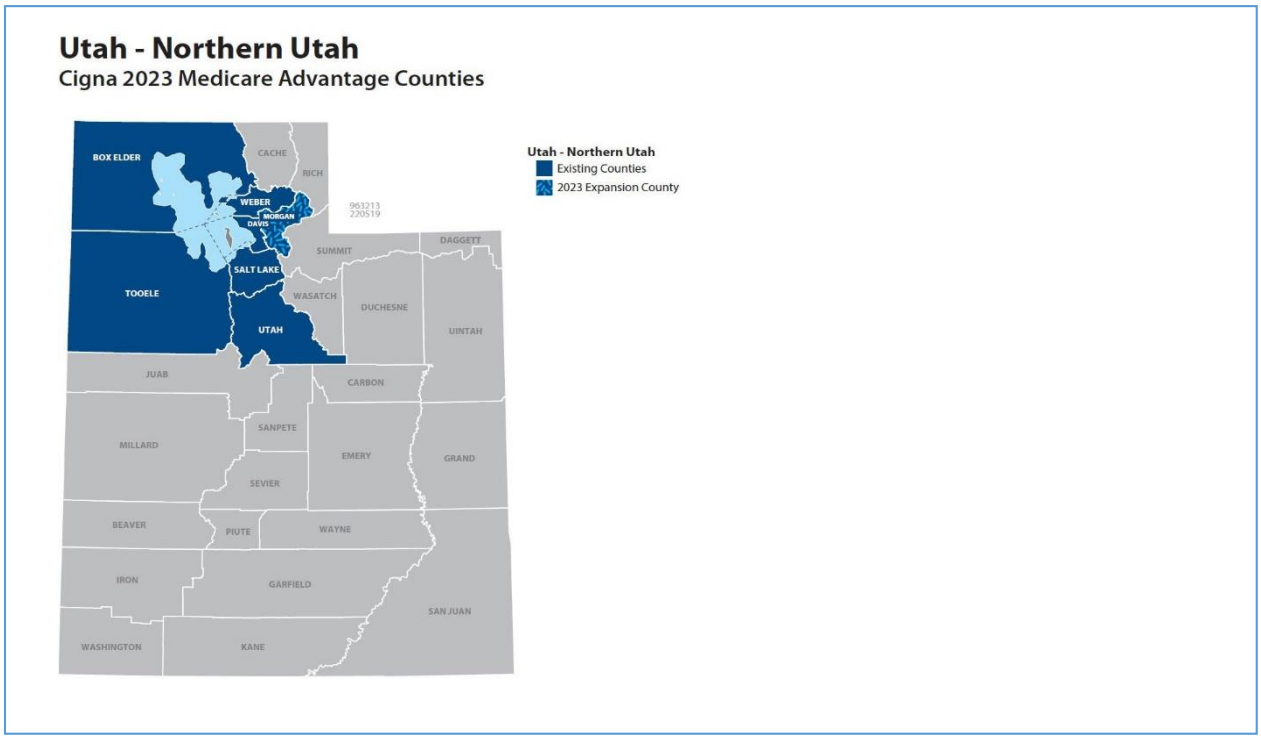
Tennessee, North Mississippi, North Georgia, and Southwest Virginia



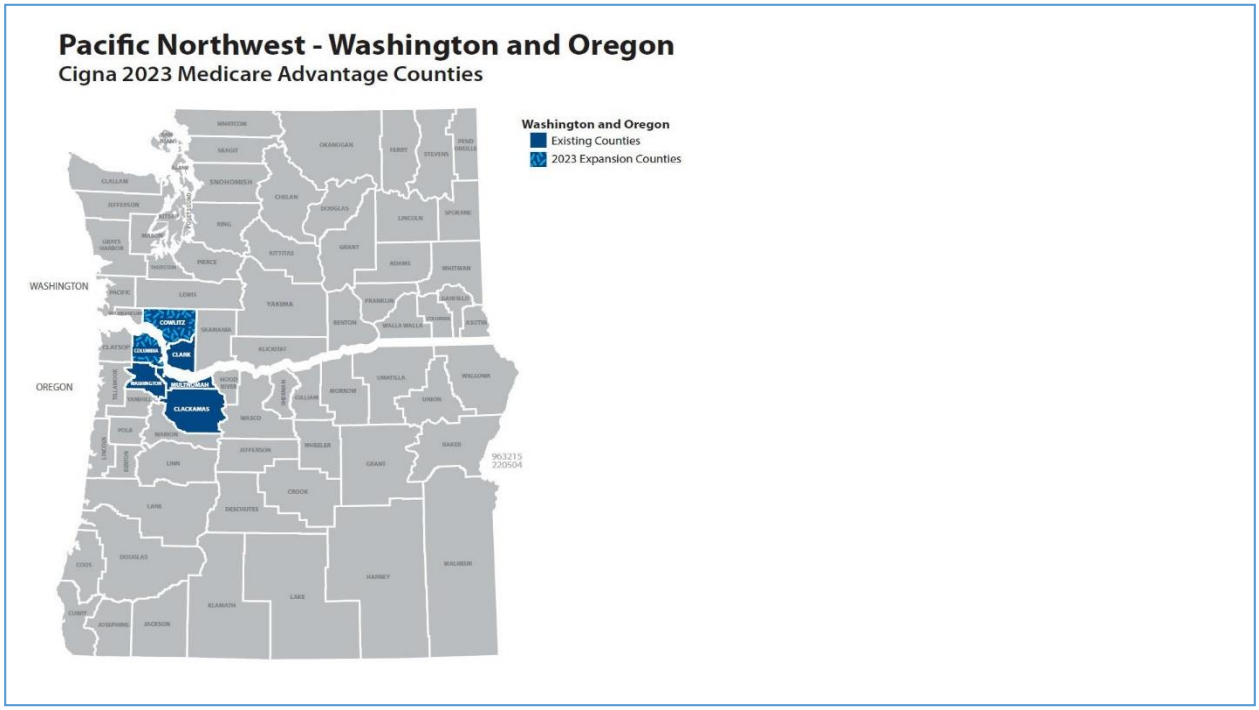
Texas



Utah



Washington and Oregon (Pacific Northwest)



Last revised December 20, 2022

