Contents

Background Information ..................................................................................................................2
Increasing Available Care .............................................................................................................2
Referral Requirements ..................................................................................................................2
Utilization Management Guidelines ..............................................................................................3
  Authorization Requirements ........................................................................................................3
Post-Acute Care, DME and Elective Procedures ............................................................................3
  Post-Acute Care Review ............................................................................................................3
  DME .........................................................................................................................................4
  Elective Surgeries and Procedures (Outpatient and Inpatient) ..................................................4
1135 Waiver Information ..............................................................................................................4
  Hospitals without Walls ..............................................................................................................4
  Hospitals at Home .....................................................................................................................4
Emergency Room and Transport ..................................................................................................4
Coronavirus Aid, Relief, and Economic Security Act (CARES Act) ..............................................5
  Sequestration ............................................................................................................................5
  Inpatient Prospective Payment System (IPPS) Hospitals- DRG Payment Increase..................6
Screening Guidelines ...................................................................................................................6
  Testing Reimbursement ............................................................................................................7
  Testing Coverage ......................................................................................................................7
  Antibody Testing .......................................................................................................................7
  Antibody Test Coverage ..........................................................................................................7
Treatment of Confirmed COVID-19 Cases .................................................................................7
Treatment of Confirmed COVID-19 Cases: Monoclonal antibodies ..........................................8
Non COVID-19 Related PCP & Specialist Services .....................................................................9
Telehealth ....................................................................................................................................9
  COVID-19 Telehealth Services ...............................................................................................9
  Non COVID-19 Telehealth Services ........................................................................................10
Billing for Telehealth Services ..................................................................................................10
  Audio Only Telehealth (CPT Codes 99441-99443) ................................................................11
  Electronic Consultations (eConsults) aka Interprofessional Consultations ............................11
CPT and Diagnosis Codes List ....................................................................................................12
Frequently Asked Questions .......................................................................................................16
These guidelines apply to Medicare Advantage and Medicare-Medicaid customers. Using these recommended billing guidelines and codes will facilitate proper payment and help avoid errors and reimbursement delays.

References made throughout this document in regards to referrals and cost-share are only applicable if required by the customer’s benefit plan.

Updated December 7th, 2020- Highlighted text indicates update

Background Information

CMS has released several memorandums, provider toolkits and guidance around COVID-19, and the changes to the healthcare environment. The most recent Clinician letter was posted by CMS on 4/7/2020 which summarizes recent changes: https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf


To keep up to date with the important work CMS is doing in response to COVID-19, visit the https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page website.

Increasing Available Care

(REVISED 12/7/2020) We recognize these are times of high demand for quality healthcare. In order to support the healthcare needs of our customers and help alleviate pressure to our existing network providers, we have implemented an accelerated initial credentialing process for providers performing critical COVID-19 related services. This process will help to ensure we are able to meet our customers’ needs by onboarding critically needed providers into the network quicker.

This accelerated initial credentialing process will be available until 3/31/2021. It is requested that providers identify their application as COVID-19 related upon submission. Standard credentialing and onboarding requirements for plan participation apply.


Referral Requirements

(REVISED 12/7/2020)

In-network Providers. Referral requirements (if required by customer’s benefit plan) are waived for in-network provider services until 1/21/2021.

Out of network Providers. Referral requirements (if required by customer’s benefit plan) are required for out-of-network provider services.
Utilization Management Guidelines  
(REVISED 6/22/2020)

Authorization Requirements
Cigna requires authorization of certain services, medications, procedures, and/or equipment prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care.

Authorization requirements apply for services provided by in and out of network providers according to plan rules as listed in the online provider manual (https://medicareproviders.cigna.com/).

Exceptions: No authorizations are required for in or out of network providers for the following:
- SARS-CoV-2 testing
- Treatment services with a COVID-19 diagnosis


Post-Acute Care, DME and Elective Procedures  
(Revised 12/7/2020)

Cigna has made the modifications below to the initial clinical reviews, DME and routine procedure requests. These modifications apply to both in and out of network providers:

Post-Acute Care Review:
In order to help facilitate freeing up bed space for COVID-19 patients, Cigna will allow emergent or urgent direct transfers for the expressed purpose of freeing up bed space for COVID-19 acute inpatient admissions to skilled nursing facilities (SNF), acute rehabilitation facilities (AR), and long-term acute care hospitals (LTACH) without prior authorization until March 31st, 2021 for both commercial and Medicare businesses.
- SNF, AR, and LTACH facilities are responsible for notifying Cigna of admissions the next business day.
- Coverage reviews for appropriate levels of care and medical necessity still apply to SNF, AR, and LTACH admissions.
- Concurrent review will start the next business day with no retrospective denials.
- Per usual policy, Cigna does not require three days of inpatient care prior to transfer to an SNF.

Please note that routine and non-emergent transfers to SNF, AR, and LTACH continue to require precertification, and if a hospital is not at capacity and requiring the need to free up bed space for COVID-19, all of these transfers still require precertification.
DME:
Documentation of face to face, physician order, and medical necessity is not required to obtain replacements of DME that is lost, destroyed, irreparably damaged or rendered unusable. All other authorization requirements for contracted providers apply unless specifically outlined in the Additional Authorization Guidelines Outside of PHE section below. The face to face waiver applies until 1/21/2021.

Elective Surgeries and Procedures (Outpatient and Inpatient):
As more healthcare providers are increasingly being asked to assist with the COVID-19 response, we ask that you consider whether non-essential surgeries and procedures can be delayed so that personal protective equipment (PPE), beds, and ventilators can be preserved. In order to assist providers with this request, routine procedure requests will be extended to six (6) months to allow for rescheduling of needed tests. Eligibility should be confirmed prior to scheduling. Also note that medical necessity review is still required.

1135 Waiver Information
(POSTED 4/24/2020)

Hospitals without Walls
On March 30th, CMS announced additional waivers and temporary rule changes in an effort to increase hospital capacity to manage patient surges due to COVID-19. Under these temporary rule changes, hospital systems are permitted to perform services outside their hospital buildings and transfer patients to other facilities (e.g. ambulatory surgical centers, inpatient rehabilitations hospitals, hotels and dormitories) while continuing to receive payment for hospital services from Medicare. This is otherwise known as known as “Hospitals without Walls”.

Hospitals must continue to exercise the necessary control and responsibility over the use of hospital resources in treating patients regardless of whether the treatment occurs in a hospital setting or outside of a hospital setting.

To ensure proper coverage and reimbursement, a facility providing care outside of a normal hospital setting should bill for the level of care provided, rather than the setting. For example, if the level of care is intensive, regardless of the setting (tent, convention center, etc.) the services should be billed as if they occurred in an ICU under the contracted facility address, Tax ID and NPI.

Emergency Room and Transport
To allow greater flexibility in providing emergency services, the following rule changes are retroactive effective 3/1/2020 through the duration of the PHE.
Emergency Departments. EDs may test and screen patients for COVID-19 at drive through and other off-campus testing sites.

Ambulances. May transport patients to a wider range of locations when other transportation is not medically appropriate. Locations may include:

- Critical Access Hospitals
- Skilled Nursing Facilities
- Community Health Centers
- Federally Qualified Health Centers
- Physician offices
- Urgent care centers
- Ambulatory surgical centers
- Dialysis Centers
- Patients home (beneficiary’s home)

Coronavirus Aid, Relief, and Economic Security Act (CARES Act)

(POSTED 4/24/2020)

As the number of COVID-19 cases in the U.S. continues to grow, the CARES Act, passed on March 27, 2020, makes a number of changes to support the ability of the health care system to respond to the crisis over the coming months. In addition, health care provisions are principally designed to offer financial support and flexibilities to providers as they care for patients during the public health emergency.

Sequestration

(Revised 12/28/2020)

Sequestration is the automatic reduction of certain federal spending as mandated by the federal budget control legislation. As a result of Sequestration, since April 1, 2013, CMS has been making a 2% payment adjustment (reduction) on Original Fee-for-Service (FFS) Medicare provider payments in addition to the premium amounts paid to Medicare Advantage Organizations like Cigna.

The CARES Act, temporarily suspends Sequestration on Medicare programs for the period beginning May, 1, 2020 and ending March 31, 2021.

Accordingly, Cigna is modifying payment for services rendered to Cigna Medicare and Medicare-Medicaid patients.

Contracted Providers

- Fee-for-Service. Cigna will continue to follow the terms of our provider contracts. Therefore, for providers that are reimbursed as a percent of Original FFS Medicare and for whom Cigna has been applying a two percent (2%) Sequestration related payment adjustment, Cigna will not apply Sequestration on claims with DOS or discharge between 5/1/2020 – 3/31/2021.

- Other Reimbursement Type. For providers whose contracts utilize a different reimbursement methodology (e.g., capitation, per diem, case rate, value based, etc.) there will be no change unless the contract specifically calls for application of
Sequestration (in which case Cigna will suspend application of Sequestration between May 1, 2020 – and March 31, 2022).

**Non-Contracted Providers**

Cigna will not apply Sequestration on claims with DOS or discharge dates of May 1, 2020 – March 31, 2021.

**Inpatient Prospective Payment System (IPPS) Hospitals- DRG Payment Increase**  
*(Revised 12/7/2020)*

Cigna increased the weighting factor of the assigned Medicare DRG by 20% for members hospitalized with a COVID-19 diagnosis and discharged during the COVID-19 Public Health Emergency (PHE) period.

Effective with admissions occurring on or after September 1, 2020, claims eligible for the 20 percent increase in the MS-DRG weighting factor will also be required to have a positive COVID-19 laboratory test documented in the patient’s medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission. For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient’s medical record to satisfy this documentation requirement. Cigna Medicare may conduct post-payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, the additional payment resulting from the 20 percent increase in the MS-DRG relative weight will be recouped.

For more information on this CMS directive please reference: [SE20015 (cms.gov)](https://www.cms.gov)

Discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following ICD-10 diagnosis codes:

- B97.29- (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
- U07.1- (2019-nCoV acute respiratory disease) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period.

Cigna will reprocess claims submitted for discharges occurring 1/27/2020 or after that have the applicable COVID-19 diagnosis codes listed. This increase will apply to contracted and non-contracted facilities.

**Screening Guidelines**

Note that state and federal mandates may supersede these guidelines.

Per the CDC, as well as state and local public health departments, it is recommended that patients first be screened virtually (i.e., by phone or video) by a clinician for potential COVID-19 symptoms. If the clinician determines SARS-CoV-2 testing is...
needed, the patient should be referred to a physician’s office or a specimen collection center for specimen collection.

**Testing Reimbursement**
*(POSTED 6/1/2020)*


Reference the [CPT and Diagnosis Codes](#) table for acceptable testing codes.

**Testing Coverage**
*(REVISED 12/7/2020)*

To help remove any barriers to receive testing, Cigna is committed to covering the laboratory tests for COVID-19.

There is no customer cost share when the FDA-approved test is performed by a laboratory and bills consistently with CMS guidelines. No prior authorization is required for testing. Home test kits that are have received FDA approval will also be covered with no cost share according to the CMS and CDC guidelines.

**Antibody Testing**
*(POSTED 4/24/2020)*

Antibody testing for SARS-CoV-2 is now available. A Coronavirus antibody test could become a key element in fighting the pandemic by providing a more accurate measure of how many people have been infected. It is not yet clear that the presence of antibodies provides immunity against re-infection.

NOTE: There are at least 4 other types of Coronaviruses that can cause a common cold and some antibody tests may have overlap of antibodies between those Coronaviruses and the SARS-CoV-2 Coronavirus. Cigna will continue to monitor and follow the guidance from the CDC in making recommendations on the utility of antibody testing.

**Antibody Test Coverage**
*(REVISED 12/7/2020)*

Cigna covers FDA approved antibody tests. Customer cost-share for FDA approved antibody tests is waived until 1/21/2021.

**Treatment of Confirmed COVID-19 Cases**
*(REVISED 12/18/2020)*

Treatment of COVID-19, according to FDA recommendations, is a covered benefit for Medicare members.
In order to ensure patients have the care they need, customer cost-share for COVID-19 treatment (inpatient and outpatient) for in-network and out-of-network providers is waived until 2/15/2021. In addition, no prior authorization is required for treatment services with a COVID-19 diagnosis.

This applies to treatment with dates of service (DOS) after 2/3/2020. Covered treatment includes all services covered under Medicare and applicable state regulations for the management of a COVID-19 diagnosis. Unless otherwise noted in this document:

- In-network providers will be reimbursed consistent with their fee schedules for services rendered.
- Out-of-network providers will be reimbursed 100% of Medicare or Medicaid allowable depending on the customer's benefit plan.

When COVID-19 is confirmed, the applicable ICD-10 codes should be used for treatment. Reference the **CPT and Diagnosis Codes** table for applicable codes to use.

**Treatment of Confirmed COVID-19 Cases: Monoclonal antibodies**

(Added 12/7/2020)

**Billing for Monoclonal Antibody COVID-19 Infusion**

- The EUA for COVID-19 monoclonal antibody treatments contain specific requirements for administration that are considerably more complex than for other services that are billed using roster billing. CMS expects that health care providers will maintain appropriate medical documentation that supports the medical necessity of the service. This includes documentation that supports that the terms of the EUAs are met. The documentation should also include the name of the practitioner who ordered or made the decision to administer the infusion, even in cases where claims for these services are submitted on roster bills.

- When COVID-19 monoclonal antibody doses are provided by the government without charge, providers should only bill for the administration. Health care providers should not include the COVID-19 monoclonal antibody codes on the claim when the product is provided for free.

**Health care providers who provide these services to enrollees in a Medicare Advantage Plan should submit claims for monoclonal antibodies to treat COVID-19 that are covered by Part B in accordance with Section 3713 of the CARES Act to Original Medicare for all patients enrolled in Medicare Advantage in 2020 and 2021.**

Reference the **Medicare Monoclonal Antibody COVID-19 Infusion Program Instruction (cms.gov)** for requirements, details and acceptable billing.
**Non COVID-19 Related PCP & Specialist Services**
*(POSTED 6/1/2020)*

COVID-19 has affected all age groups, physically, financially and emotionally. At Cigna, we want everyone to focus on getting and staying well, including those that have not been diagnosed with the virus, and not worrying about how they will access or afford the care and services they need.

That is why, as of 6/1/2020, Cigna began waiving customer cost-share for non COVID-19 related services performed *by in-network physicians until 12/31/2020*. We hope that this additional coverage will encourage customers to engage with their physicians.

This includes face to face or telehealth services received from contracted:
- Primary Care Providers
- Specialist Physicians, inclusive of:
  - Nurse Practitioners
  - Chiropractors
  - Mental Health/Behavioral Health professionals
  - Podiatrists
  - Therapists: Physical, Speech & Occupational
  - Wound Care Specialists

Applicable customer *cost-share applies* for non COVID-19 related services received from *out-of-network providers or received prior to 6/1/2020*.

**Telehealth**
*(REVISED 4/24/2020)*

Telehealth generally refers to the exchange of medical information from one site to another through electronic communication to improve a patient’s health. There are several types of telehealth services physicians can provide to Medicare and Medicare-Medicaid (MMP) beneficiaries.
- Telehealth Visits (audio & video)
- Audio Only Telehealth visits
- Virtual Check-Ins
- E-Visits (patient to provider via online portal)
- eConsults (provider to provider) also known as Interprofessional Consults

While customers are encouraged to use their telehealth benefit with providers who partner with MDLive (www.MDLive.com/CignaMedicare), providers do not have to be enrolled with, or affiliated with MDLive in order to perform telehealth services to customers.

Reference the [CPT and Diagnosis Codes](#) table for technology requirements, details and acceptable telehealth codes.

**COVID-19 Telehealth Services**
*(REVISED 10/28/2020)*

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. © 2020 Cigna
In and out-of-network providers can be reimbursed for telehealth services related to COVID-19. Customer cost-share is waived for these visits until 1/21/2021.

Non COVID-19 Telehealth Services
(REVISED 6/1/2020)

For those concerned about face-to-face encounters, Cigna is also waiving customer cost-share for non COVID-19 related telehealth services as outlined below. This allows customers not only multiple modalities to engage with their physicians but also free access to their physicians from the safety of their homes.

In-network Providers. As of 6/1/2020, Cigna is waiving customer cost-share for non-COVID-19 related telehealth services when the service is performed by a contracted provider. This waiver further supports our customers and the medical community as we work together to prevent the spread of COVID-19. Customer-cost share is waived until 12/31/2020. Customer cost-share applies for non COVID-19 related telehealth services received prior to 6/1/2020.


Billing for Telehealth Services
(POSTED 4/14/2020)

In order to allow for proper payment of telehealth services, providers should only use CPT codes allowed via telehealth by CMS. Reference the CPT and Diagnosis Codes table for accepted telehealth codes. In addition, note the following:

- **Place of Service.** Physicians and practitioners who bill for Medicare telehealth services should report the POS code that would have been reported had the service been furnished in person.

- **Modifier.** During the Public Health Emergency Period, the CPT Telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth.

CMS has published the following documents to outline telehealth services:

- **(POSTED 5/12/2020)** List of covered telehealth services:
  https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes


- Medicare Teledicine Health Care Provider Fact Sheet located at:

• (POSTED 6/1/2020) View CMS’s recently published Medicare Coverage and Payment of Virtual Services video that answers common questions about the expanded Medicare telehealth services benefit during the COVID-19 PHE. New information includes how CMS adds services to the list of telehealth services, additional practitioners that can provide telehealth services, and the distant site services that Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can provide. Further, the video includes information about audio-only telehealth services, telehealth services that hospitals, nursing homes and home health agencies can provide, along with how to correctly bill for telehealth services. See the video here: https://www.youtube.com/watch?v=Bsp5tIFnYHk&feature=youtu.be

• Need to add the recent CMS announcement (Trump Administration Drives Telehealth Services in Medicaid and Medicare | CMS & List of Telehealth Services | CMS)

Audio Only Telehealth (CPT Codes 99441-99443) (REVISED 5/4/2020)

CMS recognizes there are customers who may not have the financial means to access the equipment needed for telehealth visits requiring two-way audio and video interaction. In order to assist both providers and customers in getting the clinical care they need when video technology is absent or challenging for our customers, CMS has established separate payment for CPT codes 99441-99443 during the PHE for the COVID-19 pandemic. These new codes allow providers to perform services which typically require an office visit over the phone. Reference CMS’s Interim Final Rule with Comment for further details: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

Electronic Consultations (eConsults) aka Interprofessional Consultations (REVISED 6/1/2020)

Electronic Consultations (eConsults), aka Interprofessional Consultations, differ from E-visits. E-visits are patient to health care provider telecommunications. eConsults are health care provider to health care provider communications. eConsults can help reduce patient and physician COVID-19 exposure by allowing providers to share information in writing, online, telephonically or virtually without bringing the patient into an office setting. In order to facilitate consultation between providers during the COVID-19 pandemic, Cigna will reimburse the treating provider and the consulting provider for eConsults.

• COVID-19 eConsults. Customer cost-share is waived for eConsults with a COVID-19 diagnosis received by in and out-of-network providers until 12/31/2020.

• Non COVID-19 eConsults.
  o In-network Providers. Customer cost-share is waived for eConsults without a COVID-19 diagnosis performed by in-network providers from 6/1/2020

- **Out-of-network Providers.** Patient cost-share **applies** for eConsults without a COVID-19 diagnosis performed by out-of-network providers.

Reference the [CPT and Diagnosis Codes](#) table for COVID-19 related diagnosis codes.

### CPT and Diagnosis Codes List

**COVID-19 Related Services:**
Customer Cost-share is waived for the COVID-19 listed services when the applicable codes are used. This applies to services received by in and out of network providers until **1/21/2021**.

**Non COVID-19 Services:**
- **In-network Providers.** Customer cost-share is waived when the face to face or telehealth service is received by a contracted physician with DOS 6/1 through 12/31/2020. Cost-share applies for services received prior to 6/1/2020.

- **Out of network Providers.** Customer cost-share applies for non COVID-19 related face to face or telehealth services received by out-of-network physician.

**Reimbursement:** Providers will be reimbursed at their contracted rate or the CMS fee schedule if there is no pre-negotiated rate. Non-contracted labs will be reimbursed at their billed rate.

### DIAGNOSIS CODES FOR SCREENING & TREATMENT

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCREENING</td>
<td>Z03.818</td>
<td>Encounter for observation for suspected exposure to other biological agents ruled out. To be used for cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation.</td>
</tr>
<tr>
<td></td>
<td>Z20.828</td>
<td>Contact with and (suspected) exposure to other viral communicable diseases. Should be used for cases where there is an actual exposure to someone who is confirmed to have COVID-19.</td>
</tr>
<tr>
<td></td>
<td>Z11.59</td>
<td>Encounter for screening for other viral diseases.</td>
</tr>
<tr>
<td>TREATMENT</td>
<td>U07.1</td>
<td>2019-nCoV acute respiratory disease.</td>
</tr>
</tbody>
</table>

**New DX Codes Effective 1/1/21**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>J12.82</td>
<td>Pneumonia due to coronavirus disease 2019</td>
</tr>
<tr>
<td>M35.81</td>
<td>Multisystem inflammatory syndrome</td>
</tr>
<tr>
<td>M35.89</td>
<td>Other specified systemic involvement of connective tissue</td>
</tr>
<tr>
<td>Z11.52</td>
<td>Encounter for screening for COVID-19</td>
</tr>
<tr>
<td>Z20.822</td>
<td>Contact with and (suspected) exposure to COVID-19</td>
</tr>
<tr>
<td>Z86.16</td>
<td>Personal history of COVID-19</td>
</tr>
</tbody>
</table>

### TESTING & SPECIMEN COLLECTION CODES

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPECIMEN</td>
<td>G2023</td>
<td>Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source</td>
</tr>
<tr>
<td></td>
<td>G2024</td>
<td>Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source</td>
</tr>
<tr>
<td></td>
<td>C9803</td>
<td>Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source</td>
</tr>
<tr>
<td></td>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
</tr>
<tr>
<td>SARS-CoV-2/</td>
<td>U0001</td>
<td>This HCPC code is used for the tests developed by the Center of Disease Control and Prevention (CDC). 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel.</td>
</tr>
<tr>
<td>2019-nCoV</td>
<td>U0002</td>
<td>This HCPC code is used by laboratories performing non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). 2019-nCoV Coronavirus, SARS CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets).</td>
</tr>
<tr>
<td>TESTING</td>
<td>U0003</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.</td>
</tr>
<tr>
<td></td>
<td>U0004</td>
<td>2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.</td>
</tr>
<tr>
<td></td>
<td>U0005</td>
<td>High throughput test add-on payment; completed within two calendar days of the specimen being collected effective 1/1/2021</td>
</tr>
<tr>
<td>Revised</td>
<td>87635</td>
<td>This new CPT code became available on March 13, 2020. Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique.</td>
</tr>
<tr>
<td>10/28/2020</td>
<td>86328</td>
<td>Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
</tr>
<tr>
<td></td>
<td>86769</td>
<td>Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
</tr>
<tr>
<td></td>
<td>87426</td>
<td>Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])</td>
</tr>
<tr>
<td></td>
<td>0202U</td>
<td>Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected</td>
</tr>
<tr>
<td></td>
<td>0223U</td>
<td>Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected</td>
</tr>
</tbody>
</table>
**syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0224U</td>
<td>Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed</td>
</tr>
<tr>
<td>86408</td>
<td>Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen</td>
</tr>
<tr>
<td>86409</td>
<td>Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer</td>
</tr>
<tr>
<td>87636</td>
<td>severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique</td>
</tr>
<tr>
<td>87637</td>
<td>severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique</td>
</tr>
<tr>
<td>87811</td>
<td>severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
</tr>
<tr>
<td>0225U</td>
<td>Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected</td>
</tr>
<tr>
<td>0226U</td>
<td>Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum</td>
</tr>
<tr>
<td>0240U</td>
<td>Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected</td>
</tr>
<tr>
<td>0241U</td>
<td>Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected</td>
</tr>
</tbody>
</table>

**ANTIBODY TESTING CODES**

These codes will be reimbursed according to the CMS fee schedule.


<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTIBODY TESTING</td>
<td>86318</td>
<td>Immunoassay for infectious agent antibody(ies), qualitative or semi quantitative, single step method (eg, reagent strip).</td>
</tr>
<tr>
<td>(POSTED 4/24/2020)</td>
<td>86328</td>
<td>severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
</tr>
<tr>
<td></td>
<td>86769</td>
<td>Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
</tr>
<tr>
<td></td>
<td>86413</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative</td>
</tr>
</tbody>
</table>

**OTHER**

These codes will be reimbursed according to the CMS fee schedule.
Codes will be accepted with DOS 9/8/2020 and after. These codes will be reimbursed according to the CMS pricing once published. Additional information can be found here:

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Supplies</td>
<td>99072</td>
<td>Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease</td>
</tr>
</tbody>
</table>

**TELEHEALTH SERVICES**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-VISITS (Established Patients Only)</td>
<td>99241, 99422, 99423, G2061, G2062, G2063</td>
<td>A communication between a patient and their provider through an online patient portal. Requirement: Patient portal</td>
</tr>
<tr>
<td>VIRTUAL CHECK-IN (New or Established Patients)</td>
<td>G2012, G2010</td>
<td>A brief (5-10) minute check-in conversation between customer and provider to determine whether an office visit or other service is needed. Requirement: Audio only</td>
</tr>
</tbody>
</table>

**MEDICARE TELEHEALTH VISITS (New or Established Patients) (REVISED 5/12/2020)**

Cigna will accept CMS covered telehealth codes for COVID-19 and Non-COVID-19 related services as listed here:
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

A visit with a provider that uses telecommunication systems between a provider and patient.

**Requirement:** Video and audio (note exception below)

**Exception:** CMS has recently waived the video requirement for certain telephone evaluation and management services and has added them to the list of Medicare telehealth services. As a result, Medicare beneficiaries will be able to use an audio-only telephone to get certain telehealth services. Reference the Interim Final Rule with Comment for further details:

**ELECTRONIC CONSULTATIONS (eConsults) aka INTERPROFESSIONAL SERVICES**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>eCONSULT (Provider to Provider) (POSTED 4/24/2020)</td>
<td>99446 (5-10 min), 99447 (11-20 min), 99448 (21-30 min), 99449 (31+ min)</td>
<td>Interprofessional telephone/internet/electronic health assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional. Number of minutes for medical consultative discussion and review indicated next to code.</td>
</tr>
<tr>
<td></td>
<td>99451 (5+ min)</td>
<td>Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified healthcare professional, 5 minutes or more of medical</td>
</tr>
</tbody>
</table>

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. © 2020 Cigna
consultative time. Note that no verbal interaction between providers must occur, this can be accomplished with a written report only.

<table>
<thead>
<tr>
<th>• 99452 (30 min)</th>
</tr>
</thead>
</table>
| Interprofessional telephone/internet/electronic health **record referral service(s) provided by a treating/requesting physician** or other qualified healthcare professional, 30 minutes. This code is for use of the treating physician, NP or PA.

---

**Frequently Asked Questions**

**Utilization Guidelines**

*Initially, Cigna stated that no authorizations were required for any services for non-contracted providers until the end of the PHE 1/21/2021, what changed? (REVISED 10/28/2020)*

Cigna requires authorization of certain services, medications, procedures, and/or equipment prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care. At the beginning of the COVID-19 epidemic, it was our understanding that we could not require authorizations during the PHE for non-contracted providers. Since then, we have received clarification from CMS that authorization requirements can continue according to plan rules during the PHE period. Therefore, as of 6/22/2020, Cigna re-implemented authorization requirements as stated in the Online Provider Manual (https://medicareproviders.cigna.com/).

**Do authorization requirements now apply to non-contracted provider services with DOS 6/22 or after? (REVISED 6/22/2020)**

Yes. Any claim received from a non-contracted provider for a service listed on the 2020 authorization grid as requiring an authorization with a DOS of 6/22/2020 or after that does not have an authorization on file will be denied. Providers will need to follow the standard appeal process as necessary.

**Where are the Cigna Medicare Authorization Requirements listed? (REVISED 6/22/2020)**


Note that these requirements may change, reference our provider website for the latest information. (https://medicareproviders.cigna.com/)

**Are there any exceptions to the authorization requirements because of COVID-19? (REVISED 6/22/2020)**

Yes. Given the COVID-19 circumstances, Cigna is not requiring authorizations for treatment services with a COVID-19 diagnosis code or SARS-CoV-2 testing.

**Are authorizations still required for Home Health, SNF, LTAC and Inpatient Rehab? (REVISED 12/7/2020)**

Yes. SNF, AR, and LTACH facilities are responsible for notifying Cigna of admissions the next business day. Coverage reviews for appropriate levels of care and medical necessity still apply to SNF, AR, and LTACH admissions. Concurrent review will start the next business day with no retrospective denials. Per usual policy, Cigna does not require three days of inpatient care prior to transfer to an SNF. Please note that routine and non-emergent transfers to SNF, AR, and LTACH continue to require precertification, and if a hospital is not at capacity and requiring the need to free up bed space for COVID-19, all of these transfers still require precertification.
What is Cigna doing to help facilitate prompt transfer of patients from acute inpatient facilities?  
(Added 12/22/2020)

Cigna will allow direct emergent or urgent transfers from an acute inpatient facility to a second acute inpatient facility. The second acute inpatient facility is responsible for notifying Cigna of admissions the next business day.

Has CIGNA extended the timeframe for prior authorizations?  
(Added 12/7/2020)

Yes. Effective March 25, 2020 through March 1, 2021, for all requests received for all Cigna lines of business, we are temporarily increasing the authorization window for all elective inpatient and outpatient services from three months to six months. Elective inpatient and outpatient prior authorization decisions made between January 1, 2020 and March 24, 2020 will be assessed when the claim is received and will go payable as long as it is within six months of the original authorization.

<table>
<thead>
<tr>
<th>SARS-CoV-2 TESTING</th>
</tr>
</thead>
</table>
| Will the SARS-CoV-2 laboratory test be covered?  
(REVISED 10/28/2020)
Yes. SARS-CoV-2 testing will be covered for both in-network and out-of-network labs, and applicable customer cost-share is waived until 1/21/2021. Note that home test kits that are not FDA approved or administered by a CLIA certified lab are not covered. |
| Will the office visits for SARS-CoV-2 test be covered?  
(REVISED 10/28/2020)
Yes. Customer cost-share for physician visits for testing (both in-network and out-of-network) is waived until 1/21/2021. |
| How much will providers be reimbursed for SARS-CoV-2 testing performed by commercial labs, such as LabCorp and Quest? |
CMS has released a fee schedule to determine pricing for SARS-CoV-2 testing which varies by state.  
| Are there any prior authorizations required for SARS-CoV-2 lab testing? |
No. Prior authorization is not required for SARS-CoV-2 lab testing. |
| What if I need to test a patient for SARS-CoV-2, will I get paid for collecting the specimen?  
(POSTED 5/12/2020)
If you are a provider that can bill for an E/M service, the testing is part of the E/M service. If the patient goes in to the provider’s office just for the specimen collection, then you can bill code 99211 for the service. |
| Is a physician’s order still required for SARS-CoV-2 testing?  
(REVISED 12/7/2020)
To help ensure that Medicare beneficiaries have broad access to testing related to COVID-19, a written physician’s order is no longer required for the COVID-19 test for Medicare payment purposes. It is important that providers and customers check local state requirements as some states will not allow testing centers to test customer’s without a physician’s order. Reference the CMS Laboratory Tests Requirements notice (https://www.cms.gov/files/document/covid-ifc-2-flu-rsv-codes.pdf) which outlines... |
which lab codes do not require a physician’s order. One exception would be the home kit where the testing and results are done from a member's home. This kit requires a healthcare provider order and more information can be found here: download (fda.gov)

How should claims with no ordering physician be submitted? (POSTED 6/1/2020)
- If an order is not written, you do not need to provide the National Provider Identifier (NPI) of the ordering or referring professional on the claim.
- If an order is written, include the NPI of the ordering or referring professional, consistent with current billing guidelines.

COVID-19 MEDICAL TREATMENT

Will cost-sharing be waived for customers with costs related to COVID-19 treatment? (REVISED 12/22/2020)
Yes. Treatment of COVID-19 is covered according to the benefit plans and provider contracts as appropriate. Depending on the customer’s benefit plan, applicable deductibles and cost-sharing related to treatment for COVID-19 is waived until 2/15/2021.

What is considered COVID treatment? (POSTED 3/31/2020)
Treatment is any care given at any location (hospital, doctor’s office, urgent care, virtual care, skilled nursing facility, etc.) that contains a COVID-19 diagnosis code as listed in the Billing Guidelines.

Are there any Part D medications covered under treatment of COVID-19? (Revised 12/7/2020)
Currently there are no medications covered under Medicare Part D for the treatment of COVID-19. However, this is a fluid situation and the Medicare rules may change as the circumstances necessitate. If and when notice is received from CMS that certain drugs are covered, the medications will be covered under the customer’s Part D benefit.

What will providers be reimbursed for providing services related to COVID-19 screening and treatment?
In-network providers will be reimbursed consistent with their fee schedules for services rendered. Out-of-network providers will be reimbursed 100% of Medicare or Medicaid allowable depending on the customers benefit plan.

Will providers who cannot submit claims or request authorizations on time because of staffing shortages be penalized?
Every effort will be made to accommodate facilities and provider groups who are adversely affected by COVID-19. We may request to review the care that was provided for medical necessity post-service.

COVID-19 VACCINE (added 12/7/2020)

Q: For CIGNA Medicare Advantage or Group Medicare Advantage customers who will reimburse providers for the administration of the COVID-19 vaccine?

For calendar Years (CYs) 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration for beneficiaries enrolled in Medicare Advantage plans will be made through the original fee-for-service Medicare program. Medicare Advantage plans should inform their contracted providers about this coverage policy and direct them to submit claims for administering the COVID-19 vaccine to
For CIGNA Medicare Advantage or Group Medicare Advantage customers who will reimburse providers for the COVID-19 vaccine?

For calendar Years (CYs) 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration for beneficiaries enrolled in Medicare Advantage plans will be made through the original fee-for-service Medicare program. Medicare Advantage plans should inform their contracted providers about this coverage policy and direct them to submit claims for administering the COVID-19 vaccine to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved.

For a Medicare Advantage or Group Medicare Advantage member can providers bill the member?

No, providers that receive the COVID-19 vaccine free from the federal government are prohibited from seeking reimbursement from consumers for vaccine administration costs – whether as cost sharing or balance billing. Providers that administer vaccinations to patients without health insurance or whose insurance does not provide coverage of vaccination administration fees, may be able to file a claim with the provider relief fund, but may not charge enrollees directly for any vaccine administration costs.

What will happen if the provider bills CIGNA in error for the vaccine instead of the MAC?

The claim will be denied letting the provider know that it should be rebilled to traditional Medicare.

For more information please refer to the CMS toolkit: [COVID-19-toolkit-issuers-MA-plans.pdf](https://cms.gov)

---

**COVID-19 Telehealth Policy**

*In lieu of having an office visit, can providers that are not contracted through MDLive for telehealth services get reimbursed for telehealth services?* (REVISED 4/3/2020)

**Yes.** Physicians who bill for a telehealth visit for the duration of the COVID-19 Public Health Emergency will be reimbursed according to their contracted rate if in-network or Medicare allowable if out-of-network.

*What codes should providers use for billing telehealth services?* (REVISED 4/3/2020)

Providers should reference the CMS telehealth codes on the following website: [https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

*Can providers do the 360 Comprehensive Assessment or the Health Maintenance Record (HMR) via telehealth?* (POSTED 4/14/2020)

**Yes.** Providers must use audio and video equipment permitting two-way, real-time interactive communication between the patient and practitioner in order to complete the 360 Comprehensive...
Assessments/HMR via telehealth. The vitals section, such as blood pressure, pulse, BMI, etc., and the physical exam section of the form, are no longer required fields.


CMS recently added the annual wellness visit codes G0438 and G0439 to the list of codes that are allowed with audio only. Will Cigna still continue to require both video & audio for the 360 Comprehensive Assessment or the Health Maintenance Record (HMR) via telehealth? (POSTED 5/4/2020)

Yes. Cigna continues to require both the audio and video component for all 360 exams and will provide further guidance if that changes.

Can providers resubmit telehealth claims that were previously submitted using POS 02 instead of the in person POS code? (POSTED 4/24/2020)

Yes. Providers can submit corrected claims for reprocessing. The adjusted POS code should be included along with modifier 95 to indicate the service occurred via telehealth.

Why should providers not bill with POS 02 for telehealth services? (POSTED 4/24/2020)
Consistent with CMS guidance, billing a face-to-face place of service will ensure providers receive the same reimbursement as they typically get for a face-to-face visit.

Is using the in person POS code instead of POS 02 fraudulent since the service was not performed in person but providers are being asked to bill as if it was a face to face visit? (POSTED 4/24/2020)
CMS has implemented this coding and billing guidance as a temporary measure. CMS guidance is to append modifier 95 to the claim indicating the service was performed via telehealth. As long as providers are following CMS guidance and billing appropriately, Cigna does not consider this fraudulent.

Will providers be reimbursed for providing non-COVID-19 related services via telehealth? (POSTED 4/24/2020)
Yes. Providers will be reimbursed for COVID-19 and non-COVID-19 related telehealth services.

Who are the eligible practitioners that can perform services via telehealth? (POSTED 5/12/2020)
CMS has expanded the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services. Reference the Emergency Declarations Blanket Waivers for Health Care Providers at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

PHARMACY

Are prescription refill limits/requirements being lifted?
Our focus is to help customers stay on track with their medication. As part of our normal business practice, retail pharmacists can enter a submission clarification code to allow early refills using their
professional judgement. Cigna/Express Scripts communicated a reminder of the process to pharmacies in light of COVID-19.

**Are there any drug shortages?** *(Revised 12/7/2020)*

Our Express Scripts pharmacy network team has been keeping in close daily contact with pharmacies to monitor volumes and supply. If a local pharmacy is experiencing a challenge accessing a medication supply, patients can contact another network pharmacy, including Express Scripts Pharmacy for home delivery. If patients utilizing albuterol inhalers on a chronic basis experience a challenge, they may need to switch to albuterol solution via a nebulizer until supplies can be replenished. As there may be a risk of spreading virus laden droplets to other household members, an albuterol inhaler, if available, might still be a more appropriate choice for patients infected with COVID-19 illness.

**What if a pharmacy asks me about early refill overrides, signature pad or other related questions?** *(POSTED 3/31/2020)*

Please direct pharmacies to the Express Scripts Pharmacist Resource Center at https://PRC.Express-Scripts.com or dial 1-800-922-1557 for further assistance.

**MEMBERS IN CASE MANAGEMENT**

**What is Cigna Medicare Advantage doing to support your high risk patients in case management?** *(Revised 12/7/2020)*

All customers in CM with a COVID dx have goals and interventions specifically tailored for COVID symptoms including proper self-care around washing hands, not touching face/eyes, avoiding large groups, wearing masks as appropriate, when to call your doctor, and the importance of monitoring symptoms related to temperature, breathing, cough or shortness of breath. In addition, the following COVID resources are given as appropriate.

- United Way has a COVID-19 Community Economic Relief Fund. They will help with bills, rent and food. You can call 1-866-211-9966 and provide the zip code. You will be given a list of local agencies to provide assistance.
- 24 hour Prayer Line during COVID 888-388-2683
- MDLIVE for toll free 24 hour COVID medical assistance 866-918-7836

**CMS Advanced Payments**

**What type of financial assistance is available for providers?** *(REVISED 5/4/2020)*

In order to increase cash flow to providers of services and suppliers impacted by the 2019 Novel Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services (CMS) has expanded their Accelerated and Advance Payment Program. The expansion of this program is only for the duration of the public health emergency. Details on eligibility, the request process and listing by state are outlined here: https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf
## Additional Provider Resources

**What additional resources are available for providers?** *(REVISED 5/12/2020)*


Cigna Behavioral Health has also created the following resources to help providers cope with COVID-19 related challenges they may be facing.

- Health care workers: Self-care in stressful times webcast
- Relaxing Techniques
- Fatigue Awareness
- Self-Care Checklist
- Understanding Grief