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Introduction AND New 2020 Plan Offerings

Thank you for participating with Cigna Medicare Advantage! This provider manual has been created to assist you and your office staff in partnering with us to help improve our customer’s lives and health. It contains important information concerning our policies and procedures including claims payment and submission requirements, prior authorization and referral requirements and other helpful information. This manual is an extension of your network participation agreement and all providers are required to comply with it. This manual replaces and supersedes all other prior versions. To the extent there is any inconsistency between the terms of this manual and your network participation agreement, the terms of your network participation agreement will control. This manual is also intended to help providers more effectively do business with Cigna Medicare, so please make time to review it carefully.

Things you need to know:

Referrals
- HMO: Referral required in select plans

Quick Reference Guide
- Highlights key contacts

Local Network Information
- Regional Product Maps are located in the Appendix
- Market specific contacts are located throughout the provider manual depending on the topic
- Customer Identification Cards provide high level product / network information. Remember to contact the phone numbers on the card for assistance and follow guidance in order to verify eligibility, referral / no referral and authorization guidance.

Our Commitment and Mission

We are committed to working with hospitals, ancillary facilities, physicians and other health care professionals to help ensure that our customers (also referred to as “Participants” in your Cigna Participating Provider Agreement) have access to quality care and services. Your cooperation and compliance with the procedures outlined in this guide are essential to our keeping this commitment. As part of our mission, we strive to help the people we serve improve their health, well-being and peace of mind. We measure our performance through annual health care professional surveys and we welcome your feedback. Working together, we believe we can attain optimal outcomes.

Contact Us

Please contact us if you have questions about the information in this guide, or our plans and programs. The terms of your agreement or applicable law supersede this guide if a conflict arises.
## Notes
The term “health care professional” used throughout this guide is referred to as “provider”, “hospital”, or “group”, “you or your” in your participation agreement.

### KEY CONTACTS

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Eligibility Verification</td>
<td>Customer Service: <strong>1-800-627-7534</strong></td>
<td>Visit: <a href="http://ClaimStatMCIS.com">ClaimStatMCIS.com</a></td>
</tr>
<tr>
<td>Behavioral Health/Substance Use Disorders</td>
<td>Cigna Network (Please call for authorizations)</td>
<td>Call: <strong>1-866-780-8546</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: <strong>1-866-949-4846</strong></td>
</tr>
<tr>
<td>Claims Processing</td>
<td>For questions and claim status call Customer Service: <strong>1-800-627-7534</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use Payor ID <strong>62308</strong> when submitting electronic claims.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mail paper claims to: <strong>Cigna Medicare Advantage</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>PO Box 38639</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Phoenix, AZ 85069</strong></td>
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<tr>
<td></td>
<td>Submit appeals to: <strong>Appeals and Grievances</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>PO Box 29030</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Phoenix, AZ 85038</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Or fax: <strong>1-866-567-2474</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submit payment disputes to: <strong>Cigna Medicare Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>ATTN: Medicare Claims Department</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Provider Payment Disputes</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>25500 North Norterra Drive</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Phoenix, AZ 85085</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Or fax: <strong>1-860-731-3463</strong></td>
<td></td>
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<tr>
<td></td>
<td>Do not send disputes to PO Box. Payment disputes are disagreements in the amount allowed or paid on a claim or service and do not require medical records. For an appeal of a denied claim/service only the following need to be included: 1-admin notes, 2-ER notes, 3-Consultation notes, 4-Ops notes,</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Coding and Documentation</th>
<th><a href="https://medicareproviders.cigna.com/icd-10">https://medicareproviders.cigna.com/icd-10</a></th>
</tr>
</thead>
</table>
| Compliance               | To report potential fraud, waste, or abuse please contact Cigna’s Special Investigations Unit  
                              By mail: Cigna, Attn: Special Investigations Unit  
                              PO Box 20002, Nashville, TN 37228  
                              By email: [specialinvestigations@cigna.com](mailto:specialinvestigations@cigna.com)  
                              Attn: Cigna Medicare Operations  
                              By phone: **1-800-667-7145** |
| Council for Affordable Quality Healthcare (CAQH®) | [https://proview.caqh.org](https://proview.caqh.org) |
| Dental Services          | Cigna Dental Customer Service **1-800-367-1037** |
| Supplemental Benefits    | For questions concerning Supplemental Benefits, please call Provider Customer Service at **1-800-627-7534** |
| Outpatient Laboratory Services | **LabCorp** | Call: **1-888-522-2677**  
                              **Sonora Quest Diagnostic Laboratories** |  
                              Call: **602-685-5000 or 800-766-6271** |
| Prior Authorization (Non-Pharmacy) | Prior Authorization must be obtained for the following services: Inpatient and Elective Admission Notification, Home Health Care, DME, and Outpatient Services.  
                              Provider Customer Service at **1-800-627-7534** |
                              Formulary Website: [https://www.cigna.com/medicare/part-d/drug-list-formulary](https://www.cigna.com/medicare/part-d/drug-list-formulary) |  
                              Fax: **1-866-845-7267** |
Medicare Overview

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

Arizona offers three (3) Advantage plans in Maricopa County and one (1) in Pima.

Maricopa County plans:
- Preferred
- Achieve Plus, SNP (Special Needs plan for Diabetics)
- Alliance Network

Pima County plans:
- Preferred

Service areas are shown on page 98

**Cigna Medicare Advantage HMO Plans:** Customers are required to select a PCP and must receive all covered services by utilizing In-network providers, except in the case of emergency. Select service areas do not require the use of referrals. Please refer to the ID card section to identify customers with HMO plans that do not require referrals.

Office Guidance

Benefits/Eligibility Verification and ID Cards

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

**How to Verify Customer Eligibility**
You can verify customer eligibility the following ways:
Please note: Cigna should have the most updated information; therefore, call Cigna to verify eligibility when the patient cannot present identification or does not appear on your monthly eligibility list.

Provider Services: 1-800-627-7534, Hours Monday-Friday: 8 am - 5 pm

Use ClaimStat. ClaimStatMCIS.com

Ask to see the patient’s Identification Card. Each patient is provided with an individual patient identification card. Noted on the ID card is the patient’s identification number, plan code, name of PCP, copayment, and effective date. Since changes do occur with eligibility, the card alone does not guarantee the patient is eligible.

Pursue additional proof of identification. Each PCP office is provided with a monthly member roster upon request, which lists new and current Cigna customers with their effective dates. Please be sure to refer to the most current month’s member roster.

Exchange of Electronic Data

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

Cigna will engage with a provider’s staff to appropriately implement the connection. Any files placed for receipt by provider staff must be downloaded in 24 hours, as all data is deleted on a fixed schedule. If the files are unable to be downloaded, then alternate arrangements for retransmission must be made. The provider and provider’s staff will work collaboratively with Cigna to ensure information is adequately protected and secure during transmission.
2020 Example ID Cards

**MAPD**
Achieve Plus (Diabetic) Plan

![Achieve Plus (Diabetic) Plan ID Card](image1)

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**Alliance Plan**

![Alliance Plan ID Card](image2)

**Preferred Plan**

![Preferred Plan ID Card](image3)
Dual Eligible

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

Providers can accept Cigna’s payment as payment in full or seek additional payment from the appropriate state source. Additional information concerning Medicaid provider participation is available at: www.cigna.com/medicare

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

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

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

Medicaid Coverage Groups

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

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

Specified Low-Income Medicare Beneficiary (SLMB Only)
An “SLMB” is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than 120% FPL, and whose resources do not exceed twice 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 Part A, has income that is at least 120% FPL but less than 135% FPL, resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. A QI is similar to an SLMB in that the only benefit available is Medicaid payment of the Medicare Part B premium; however, expenditures for QIs are 100% federally funded and the total expenditures are limited by statute.

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 who does not meet the income or resource criteria for QMB or SLMB.

Qualified Disabled and Working Individual (QDWI)
A “QDWI” is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. QDWIs are eligible only for Medicaid payment of Part A premium.

Access and Availability Standards for Providers
- A Primary Care Physician (PCP) must have their primary office open to receive Cigna customers five (5) days and for at least 20 hours per week.
- The PCP must ensure that coverage is available 24 hours a day, seven days a week.
- PCP offices must be able to schedule appointments for Cigna customers at least two (2) months in advance of the appointment.
- A PCP must arrange for coverage during absences with another Cigna Participating Provider in an appropriate specialty which is documented on the Provider Application and agreed upon in the Provider Agreement.

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

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

Please ensure your office staff are available and trained to not only answer access and availability questions but to assist customers with their routine, urgent and emergent care needs. Cigna will notify you in writing if your office fails to meet any of the access and availability standards as part of the survey. A Cigna representative will contact your office directly if a grievance is received in regards to access and availability for your office.

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
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<tbody>
<tr>
<td>Urgent/Emergent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-urgent/non-emergent</td>
<td>Within one week</td>
</tr>
<tr>
<td>Elective</td>
<td>Within thirty business days</td>
</tr>
<tr>
<td>High index of suspicion of malignancy</td>
<td>Less than seven days</td>
</tr>
<tr>
<td>Waiting time in office</td>
<td>Thirty minutes or less</td>
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SPECIALIST ACCESS STANDARDS

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<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
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<tbody>
<tr>
<td>Urgent/Emergent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-urgent/non-emergent</td>
<td>Within one week</td>
</tr>
<tr>
<td>Elective</td>
<td>Within thirty business days</td>
</tr>
<tr>
<td>High index of suspicion of malignancy</td>
<td>Less than seven days</td>
</tr>
<tr>
<td>Waiting time in office</td>
<td>Thirty minutes or less</td>
</tr>
</tbody>
</table>

BEHAVIORAL HEALTH ACCESS STANDARDS

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and non-life threatening</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent/symptomatic</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Routine</td>
<td>Within 10 business days</td>
</tr>
</tbody>
</table>

| Urgent/Emergent | Immediately |
| Non-urgent/non-emergent | Within one week |
| Routine and preventive | Within thirty business days |
| On-call response (after hours) | Not to exceed an hour in the event of an emergency |
| Waiting time in office | Thirty minutes or less |
# Provider Directory Update Requirements

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

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

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

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

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

<table>
<thead>
<tr>
<th>If you want to:</th>
<th>Use the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update your provider directory demographic information, or notify us of errors/changes to the way you are currently listed in our provider directories, including: Name</td>
<td>Log in to the <a href="https://www.cigna.com">Cigna for HealthCare Professionals</a> website to use our updated online change form. If you haven’t registered yet, please go to the <a href="https://www.cigna.com">registration page</a> to begin the process. Or Email: <a href="mailto:AZMA_PDV@Cigna.com">AZMA_PDV@Cigna.com</a> Fax: 877.358.4301 Mail: Cigna Provider Data Management Two College Park Dr. Hooksett, NH 03106</td>
</tr>
<tr>
<td>Type/Degree</td>
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<tr>
<td>Specialty</td>
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<tr>
<td>Product and network tier</td>
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<tr>
<td>National Provider Identifier (NPI) number</td>
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<tr>
<td>Medical group or hospital affiliation</td>
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<tr>
<td>Office email address</td>
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<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Office phone number</td>
<td></td>
</tr>
<tr>
<td>Whether you are accepting new customers</td>
<td></td>
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</tbody>
</table>
Provider Termination
Cigna is required to make good faith efforts to provide 30 calendar days advance written notice to impacted customers when a provider is being terminated or leaving the network. Impacted customers are those who are seen on a regular basis by the provider, have scheduled services with the provider or have recently received treatment or a service from the provider (within the past 90 calendar days). Providers must give advanced written notice (timeframe varies based on the provider services agreement) to Cigna prior to terming their agreement or leaving the network (retiring, office closure, moving out of area, etc.). Reference your Participating Provider Agreement for termination notification requirements.

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

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

- Practice address.
- Billing address.
- Fax or telephone number.
- Hospital affiliations.
- Practice name.
- Providers joining or leaving the practice (including retirement or death).
- Provider taking a leave of absence.
- Practice mergers and/or acquisitions.
- Adding or closing a practice location.
- Tax Identification Number (please include W-9 form).
- NPI number changes and additions.
- Changes in practice office hours, practice limitations, or gender limitations.
- Terminations (refer to the Provider Termination section)

By providing this information in a timely manner, you will help ensure that your practice is listed correctly in the provider directory.

Please note: Failure to provide up to date and correct information regarding demographic information regarding your practice and the physicians that participate with your practice may result in the suppression of your information in the online directory or denial of claims for you and your physicians. Suppressing your information means customers and other providers will not see you listed as a Participating Provider in our directory which can cause your practice to lose customers.
Additional Quarterly Provider Directory Data Attestation Details:

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

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

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

1. Login to the site using the individual provider NPI number and username contained in the notification.
2. Review and update all the required fields to make sure customers can find you.
   a. Ensure you indicate current practice name, suite number, whether you are accepting new customers, etc., so the most accurate and up-to-date information is included in directories.
   b. Avoid duplicate addresses. If one location (e.g., a medical complex) houses multiple practices, be sure to include suite numbers to distinguish the addresses.
   c. Describe your practice affiliation for each location so health plans can determine whether it belongs in their directories.
   d. Indicate the health plans you accept at the practice location level, since health plan participation may vary by location. You are not being asked to specify networks/products for a health plan at this time.
   e. Share the phone number customers can call to make an appointment in the “Office Phone Number” field.

3. If the information is correct and no changes are needed, check the attestation boxes verifying the information is accurate.

4. A Thank You page will appear once changes have been submitted.

5. Log out once all changes have been submitted.

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

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

**Credentialing**

All practitioner and organizational applicants to Cigna must meet basic eligibility requirements and complete the credentialing process prior to becoming a Participating Provider. When Network Operations notifies Credentialing to start the credentialing process, every provider undergoes a rigorous verification process that includes primary and secondary source verifications of all applicable information for the contracted specialty(s).

Cigna does not discriminate in terms of participation, reimbursement, or based on the population of customers serviced, against any health care professional who is acting within the scope of his or her license or certification under state law. In order to participate in the Cigna network, providers undergo a screening process before a contract can be extended.

Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied participation with the plan. No provider can be assigned a health plan effective date, be included in a provider directory, or have customers assigned without completing the credentialing and...
peer review process. All providers who have been initially approved for participation are required to re-credential at least once every three years (i.e., every 36 months) in order to maintain participation status.

**Practitioner Selection Criteria**

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

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

**Application Process**

1. Complete and submit a Network Interest Form to Network Operations. Network Operations will review each practitioner for eligibility, current contract status and network need. If approved for a contract, Network Operations will send a credentialing packet that will include a contract (unless a current group agreement already exists) a Provider Information Form (PIF) and a W-9 form that must be completed and signed. If the provider utilizes the Council for Affordable Quality HealthCare (CAQH) Proview system, practitioner must ensure that all information contained in their CAQH profile is current, including the attestation signature date, and that they have given Cigna / Cigna permission to access the CAQH information. If the provider does not utilize CAQH, the provider may contact CAQH at 1-888-599-1771 to request a paper application. An application form may also be included in the credentialing/contract packet and must be completed and returned by the practitioner along with the contract.

2. All credentialing applications must contain the following information to be considered 'complete':
   - All current and active state medical licenses, DEA certificate(s), and state controlled substance certificate as applicable.
   - Evidence of current malpractice insurance that includes 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 (6) months.
d. If any of the Professional Disclosure questions are answered ‘yes’ on the application, supply sufficient additional information and explanations.

e. Provide appropriate clinical detail for all malpractice cases that are pending, or resulted in a settlement or other financial payment within the last 5 years.

f. If a physician, include current and complete hospital affiliation information on the application. If no hospital admitting privileges and the specialty warrants hospital privileges, a letter detailing the alternate coverage arrangement(s) or the name of the alternate admitting physician must be provided.

g. Application must be signed and dated.

3. Once a completed and signed contract/credentialing packet has been received, Contracting will submit a request to Credentialing to start the credentialing verification process and forward any application information that was received. If an existing contract, once a completed and signed contract/credentialing packet has been received, Network Operations will submit a request to Credentialing to start the credentialing verification process and forward any application information that was received.

4. Credentialing logs all received applications and begins the verification process. Applications are processed by the date that they are received unless Network Operations indicates that there is a specific customer or network need that requires more expedited processing.

5. Once the credentialing process is complete, Network Operations will send you a welcome letter that contains the participation effective date. Any requests for payment for services rendered to a Cigna customer prior to the participating effective date shall be denied.

Credentialing and Re-credentialing Process

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

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

Office Site Evaluations

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

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

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

Practitioner Rights

• Right to review information obtained from any outside source to evaluate their credentialing application with the exception of references, recommendations or other peer-review protected information. The provider may submit a written request to review his/her file information at least thirty days in advance at which time the Plan will establish a time for the provider to view the information at the plan’s offices.

• Right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the practitioner. In instances where there is a substantial discrepancy in the information, Credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within thirty (30) days of notification.

• Right to be informed of the status of their application upon request. A provider may request the status of the application by calling the Provider Customer Service Center for assistance - The Plan will respond within two business days for telephonic requests and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status. Written/electronic requests will be responded to within 15 business days.

Organizational Provider Selection Criteria

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

• Must be in good standing with all state and federal regulatory bodies.

• Has been reviewed and approved by an accrediting body deemed by Medicare or recognized by Cigna.

• If not accredited, must provide a copy of a survey conducted by a state of federal agency within the 36 months prior to app submission which contains the corrective action plan for any identified deficiencies and proof of state/federal acceptance of the corrective action and/or current compliance with Medicare/Medicaid program requirements.

• Organizations that are not accredited or have not been surveyed by a state or federal regulatory body within the last 36 months may be subject to a health plan conducted site audit.

• Maintains current professional and general liability insurance as applicable.
• Has not been excluded, precluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.

• Is currently enrolled in an active status with Medicare, including any sub-entities and/or additional National Provider Identifier (NPI) numbers the organization may utilize.

Organizational Provider Application and Requirements

• A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.

• If responding, "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.

• Copies of all applicable state and federal licenses (i.e. facility license, DEA, CLIA certificate, Pharmacy license, etc.).

• Proof of current professional and general liability insurance as applicable.

• Proof of Medicare enrollment per site if submitting multiple locations

• If accredited, proof of current accreditation.
  o Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.

• If not accredited, a copy of any state or CMS site surveys that occurred within the last three years including evidence that the organization successfully remediated any deficiencies identified during the survey.

Organizational Site Surveys
As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, free-standing 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 - Accreditation for DME, Orthotics, and Prosthetic Providers
All Durable Medical Equipment (DME) and Orthotics and Prosthetic providers are required by Medicare to be accredited by one of the 10 national accreditation organizations. The most current listing of these organizations can be found at:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizationsCMB.pdf

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

• Evidence the pharmacy has been enrolled with Medicare as a supplier of Durable Medical Equipment (DME) prosthetics, orthotics, and suppliers and has been issued a provider number for at least five (5) years.

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

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

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

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

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

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

**CMS Preclusion List**

As of January 1, 2019, CMS has begun to publish a Preclusion List which lists providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

**What is the Impact?**

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

- Part D sponsors must reject pharmacy claims (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List.
- MA plans must deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

**Who is on the list?**

Individuals or entities who meet the following criteria:

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

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

Yes. CMS sends an email and letter to the provider or entity in advance of their inclusion on the Preclusion List. The email and letter is sent to the Provider Enrollment Chain and Ownership System (PECOS) address or National Plan and Provider Enumeration System (NPPES) mailing address. The letter includes the reason for the preclusion, the effective date of the preclusion, and applicable rights to appeal.

For more information on the preclusion list, visit: [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html)

**Provider Directory**

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

Claims

Claims Submission
While Cigna prefers electronic submission of claims, both electronic and paper claims are accepted. If you are interested in submitting claims electronically (EDI), contact Cigna Provider Services for assistance at 1-800-627-7534.

Electronic claims may be submitted through:
- Payor ID 62308

ERA/EFT Enrollment Process

Electronic payment options help save time and simplify reconciliation. We are pleased to continue offering simpler, more efficient ePayment Solutions to help you maximize revenue and profit, reduce costs and errors and increase payment efficiency.

EFT Enrollment Guidelines

- For savings account deposits, verify that your bank will support EFT.
- The enrollment process typically takes two to six weeks.
- 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 (HRA, HSA, FSA) is not included with the Cigna medical payment, it will be mailed to you within 48 hours.

Choose How to Bulk Your EFT Payments
When you enroll in EFT with Cigna, you can choose to have your payments grouped or bulked either of two ways:

- Based on your Taxpayer Identification Number (TIN) and payment address,
  or
- By your Billing Provider National Provider Identifier (NPI) from your submitted claims.

If you already receive EFT payments and wish to change the method by which your payments are bulked, log in to CignaforHCP.com > Working with Cigna > Manage EFT Settings, then you'll be able to update your payment preferences from this page.

Enroll in EFT – Two Options

- Enroll in EFT with multiple payers, including Cigna, using the Council for Affordable Quality Health Care (CAQH) website.
Enroll in EFT directly with Cigna by logging in to CignaforHCP.com > Working with Cigna > Enroll in Electronic Funds Transfer (EFT) Options.
  – Complete the electronic enrollment form.
  – Cigna sends a "pre-note" transaction to your bank to verify all the banking information is correct:
    o If the pre-note is not returned to Cigna, you begin receiving EFT on your next payment cycle
    o If the pre-note is returned with errors, Cigna contacts you to obtain correct banking information
  – To check the status of your EFT application, log in to CignaforHCP.com > Working with Cigna > Manage EFT Settings.

If you're not yet registered for the Cigna for Health Care Professionals website, go to CignaforHCP.com and click "Register Now."

Electronic Remittance Advice
When used together, EFT and electronic remittance advice (ERA) can help eliminate claims payment paperwork and improve your cash flow.

Online Remittance Reports
Access your Cigna remittance reports online the same day you receive your electronic deposit. Learn more

Shorten Your Payment Cycle. Enroll in EFT and ERA Today.

- To enroll in EFT, log in to CignaforHCP.com or the CAQH website.
- To enroll in ERA with Cigna, contact your EDI vendor.
- Learn more about Electronic Funds Transfer and Online Remittance Reports or call 1.800.88Cigna (882.4462).

Paper Claims Submission

Cigna Medicare Advantage Medicare Advantage
PO Box 38639
Phoenix AZ 85069-8639

Supporting claim documents (i.e. medical records, itemized bills, EOBs, etc.) should be submitted with original submission, paper and EDI. However, supporting documents can be faxed to: 602-792-6332 upon Cigna Medicare Advantage request or mailed to address above.

Timely Filing
As a Cigna participating provider, you have agreed to submit all claims within the timeframes 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 at https://www.cms.gov/manuals/downloads/clm104c12.pdf. Appropriate forms and data elements must be present for a claim to be considered a clean claim.
Cigna can only pay claims which are submitted accurately. The provider is always responsible for accurate claims submissions. While Cigna will make its best effort to inform the provider of claims errors, responsibility for claim accuracy rests solely with the provider.

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

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

**Claim Format Standards**

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

**CLIA Certification Required for Laboratory Services**

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

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

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

**Offsetting**
As a contracted Cigna provider, you will be informed of any overpayments or other payments you may owe us. You will have thirty (30) days from receipt of our repayment demand to refund such amounts to us. We will provide you with the patient’s name, identification number, Cigna’s claim number, your customer account number, date of service, a brief explanation of the recovery request, and the amount or the requested recovery. If you have not refunded us within the thirty (30) day recovery period, we will offset the recovery amounts identified in the initial repayment demand, or in accordance with the terms of your agreement, unless an appeal or refund is received. Notwithstanding the foregoing, any CMS fee schedule or pricing changes will be automatically applied and effective upon the date specified by CMS. Evidence of such adjustments shall be included in the explanation of payment/remittance advice.

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

**Claims Encounter Data**
Claim encounter data is Providers who are being paid under capitation must submit claims in order to capture encounter data as required per your Cigna Provider Agreement.

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

**Prompt Payment**
Cigna will pay participating providers in accord with the prompt payment provisions of their contracts.

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

**Pricing of Inpatient Claims**

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

**Skilled Nursing Facility Consolidated Billing (SNF CB)**

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

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

**Processing of Hospice Claims**

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

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

**Hospice-Related Services**

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

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

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

Non-Hospice Services

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

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

ICD-10 Diagnosis and Procedure Code Reporting

In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors, and other health care professionals, as well as vendors and trading partners.

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

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

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

  ![ICD-10-CM Example](image)

- **ICD-10-PCS** for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric characters instead of the 3 or 4 numeric characters used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

  ![ICD-10-PCS Example](image)

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

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

**Billable vs. Non-Billable Codes**

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

<table>
<thead>
<tr>
<th>BILLABLE ICD-10 CODES</th>
<th>NON-BILLABLE ICD-10 CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1A.3110 - Chronic gout due to renal impairment, right shoulder, without tophus</td>
<td>M1A.3 - Chronic gout due to renal impairment</td>
</tr>
</tbody>
</table>
*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 have a question as it pertains to ICD-10, please refer to the Provider Resource tools on Cigna ICD-10 website at [www.MedicareProviders.Cigna.com/icd-10](http://www.MedicareProviders.Cigna.com/icd-10)

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### Coordination of Benefits

Coordination of Benefits (COB) and Subrogation Guidelines

### General Terms and Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>

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

### National Association of Insurance Commissioners (NAIC) Rules

**Birthday Rule**
The primary coverage is determined by the birthday that falls earliest in the year, understanding both spouses are employed and have coverage. Only the day and month are taken into consideration. If both customers have the same date of birth, the plan which covered the customer the longest is considered primary.

**General Rules**
The following table contains general rules to follow to determine a primary carrier:

<table>
<thead>
<tr>
<th>IF THE CUSTOMER/BENEFICIARY</th>
<th>THE BELOW CONDITION EXISTS</th>
<th>THE BELOW PROGRAM PAYS FIRST</th>
<th>THE BELOW PROGRAM PAYS SECONDARY</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>Condition</th>
<th>Employer Details</th>
<th>Cigna/Medicare Details</th>
<th>Medicare Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family member’s current employment</td>
<td>The employer has more than 20 employees, or at least one employer is a multi-employer group that employs 20 or more employees</td>
<td>The Group Health Plan (GHP) pays primary</td>
<td>Cigna/Medicare pays secondary</td>
</tr>
<tr>
<td>Is age 65 or older and is covered by a Group Health Plan (GHP) through current employment or a family member’s current employment</td>
<td>The employer has less than 20 employees</td>
<td>Cigna/Medicare pays primary</td>
<td>Group Health Plan (GHP) pays secondary</td>
</tr>
<tr>
<td>Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family member’s current employment</td>
<td>The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees</td>
<td>The Large Group Health Plan (LGHP) pays primary</td>
<td>Cigna/Medicare pays secondary</td>
</tr>
<tr>
<td>Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family member’s current employment</td>
<td>The employer employs less than 100 employees</td>
<td>Cigna/Medicare pays primary</td>
<td>Large Group Health Plan (LGHP) pays secondary</td>
</tr>
<tr>
<td>Is age 65 or older or entitled based on disability and has retirement insurance only</td>
<td>Does not matter the number of employees</td>
<td>Cigna/Medicare pays primary</td>
<td>Retirement Insurance pays secondary</td>
</tr>
<tr>
<td>Is age 65 or older or is entitled based on disability and has COBRA coverage</td>
<td>Does not matter the number of employees</td>
<td>Cigna/Medicare pays primary</td>
<td>COBRA pays secondary</td>
</tr>
<tr>
<td>Becomes dually entitled based on age/ESRD</td>
<td>Had insurance prior to becoming dually entitled with ESRD as in block one above</td>
<td>The Group Health Plan (GHP) pays primary for the first 30 months</td>
<td>Cigna/Medicare pays secondary (after 30 months Cigna pays primary)</td>
</tr>
<tr>
<td>Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance</td>
<td>Had insurance prior to becoming dually entitled with ESRD as in block one above and then retired</td>
<td>The Retirement Insurance pays primary for the first 30 months</td>
<td>Cigna/Medicare pays secondary (after 30 months Cigna pays primary)</td>
</tr>
</tbody>
</table>
Basic Processing Guidelines for COB

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

When Cigna is the secondary insurance carrier:

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

When Cigna is the primary insurance carrier:

- The provider collects the copayment required under the patient’s Cigna plan.
- Submit the claim to Cigna first
- Be sure to have the customer sign the “assignment of benefits” sections of the claim form.
- Once payment and/or Remittance Advise (RA) has been received from Cigna, submit a copy of the claim with the RA to the secondary carrier for adjudication.
  - Please note: Cigna is a total replacement for Medicare.
- Medicare cannot be secondary when customers have Cigna.
- Medicaid will not pay the copay for Cigna customers.
Worker's Compensation
Cigna does not cover worker’s compensation claims. When a provider identifies medical treatment as related to an on-the-job illness or injury, Cigna must be notified. The provider will bill the worker’s compensation carrier for all services rendered, not Cigna.

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

Customers who may be covered by third party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to Cigna with any information regarding the third party carrier (i.e. auto insurance name, lawyers name, etc.). All claims will be processed per the usual claims procedures.

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

Appeals/Payment Disputes

Appeals
Cigna offers Contracted Providers One Level of Appeal. 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. You must receive a notice of denial, or remittance advice before you can submit an appeal. Please do not submit your initial claim in the form of an appeal. Appeals can take up to 60 days for review and determination. Timely filing requirements are not affected or changed by the appeal process or by the appeal outcome. If an appeal decision results in approval of payment contingent upon the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in the Cigna agreement.

You may appeal a previous decision not to pay for a service. For example, claims denied for no authorization or no referral, including a decision to pay for a different level of care; this includes both complete and partial denials. Examples of partial denials include: denials of certain levels of care, isolated claim line items not related to claims reconsideration issues, or a decreased quantity of office or therapy visits not related to claims reconsideration issues. Total and partial denials of payment may be appealed using the same appeal process. Your appeal will receive an independent review by a Cigna representative not involved with the initial decision. Requesting an appeal does not guarantee that your request will be approved or that the initial decision will be overturned. The appeal determination may fully or partially uphold the original decision. You may appeal a health services or Utilization Management denial of a
service not yet provided, on behalf of a patient. The customer must be aware that you are appealing on his or her behalf. Customer Appeals are processed according to Medicare guidelines.

An Appeal must be submitted within 60 days of the original decision unless otherwise stated in your provider agreement. With your appeal request, you must include: an explanation of what you are appealing along with the rationale for appealing, a copy of your denial, any medical records that would support the medical necessity for the service, hospital stay, or office visit, and a copy of the insurance verification completed on the date of service. If necessary medical records are not submitted, the request will be returned without action until the medical records are submitted and must be received within the timeframe for which the provider must submit their request for appeal.

You must submit your appeal using the “Request for Appeal or Reconsideration” form and medical records. There are two ways to submit your appeal to Cigna.

You can submit appeals to:

Appeals and Grievances
PO Box 29030
Phoenix AZ 85038

Or fax: 1-866-567-2474

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

Submit payment disputes to:
Cigna Medicare Advantage
ATTN: Medicare Claims Department
Provider Payment Disputes
25500 North Norterra Drive
Phoenix AZ 85085

Or fax: 1-860-731-3463 – Do not send disputes to PO Box.

Member Medical Records

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

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

Closing Customer Panels
When a participating Primary Care Physician elects to stop accepting new customers, the provider’s customer panel is considered closed. If a participating Primary Care Physician closes his or her customer panel, the decision to stop accepting new customers must be communicated to Cigna and must apply to all customers regardless of insurance coverage. Providers may not discriminate against Cigna customers by closing their customer panels to Cigna customers only, nor may they discriminate among Cigna customers by closing their panel to certain product lines. Providers who decide that they will no longer accept any new customers must notify Cigna Network Operations, in writing, at least 30 days before the date on which the customer panel will be closed or the time frame specified in your contract.

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

Customer Management
Behavioral Health Services
Overview
Cigna provides comprehensive behavioral health and substance use disorder services to its customers. Its goal is to treat the customer in the most appropriate, least restrictive level of care possible, and to maintain and/or increase functionality.

Cigna’s network is comprised of behavioral health and substance use disorder services and providers who identify and treat customers with behavioral health care needs. Integration and communication among behavioral health and physical health providers is most important. Cigna encourages and facilitates the exchange of information between and among physical and behavioral health providers. Customer follow-up is essential. High risk customers are evaluated and encouraged to participate in Cigna’s behavioral health focused case management program where education, care coordination, and support is provided to increase patient’s knowledge and encourage compliance with treatment and medications. Cigna works with its providers to become part of the strategy and the solution to provide quality behavioral health services.

Behavioral Health Services
Behavioral Health services are available and provided for the early detection, prevention, treatment, and maintenance of the patient’s behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a customer may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Behavioral health and substance use disorder benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care.

Behavioral Health Services Include:
- Access to Cigna’s Customer Service for orientation and guidance
- Routine outpatient services to Psychiatrists, Psychologists, Licensed Clinical Social Workers, and Psychiatric Nurse Practitioners. PCPs may provide behavioral health services within their scope of practice
- Initial evaluation and assessment
- Individual and group therapy
- Psychological testing according to established guidelines and needs
- Inpatient hospitalization
- Medication management
- Partial hospitalization programs

Responsibilities of Behavioral Health Providers
Cigna’s behavioral health providers’ responsibilities include but are not limited to:
- Provide treatment in accordance with accepted standards of care
- Provide treatment in the least restrictive level of care possible
- Communicate on a regular basis with other medical and behavioral health practitioners who are treating or need to treat the patient
- Direct customers to community resources as needed to maintain or increase patient’s functionality and ability to remain in the community

**Responsibilities of the Primary Care Physician**
The PCP can participate in the identification and treatment of their patient’s behavioral health needs. His/her responsibilities include:

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

**Access to Care**
Customers may access behavioral health services as needed:

- Customers may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment
- Customers may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP’s scope of practice. They may request a referral to a behavioral health practitioner. Referrals however, are not required to receive most in-network behavioral health or substance use disorder services
- Customers and providers can call Cigna Behavioral Health Customer Service to receive orientation on how to access behavioral health services, provider information, and Prior Authorizations at 1-800-780-8546.

**Medical Record Documentation**
When requesting Prior Authorization for specific services or billing for services provided, behavioral health providers must use the current DSM multi-axial classification system and document a complete diagnosis. The provision of behavioral health services requires progress note documentation that corresponds with day of treatment, the development of a treatment plan, outcome of treatment and the discharge plan as applicable for each customer in treatment.

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

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

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

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

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

High-Tech Radiology Program

Program Overview
EviCore Healthcare is the largest Specialty Benefits Manager in the United States and offers proven, diversified medical benefits management solutions that focus on patient-centered care coordination. The company provides these solutions to managed care and risk-bearing provider organizations service Commercial, Medicare and Medicaid populations. Powered by a team of specialized medical professionals, extensive evidence-based guidelines, and advanced technologies, eviCore supports clients and participating providers by ensuring the right evidence-based care is delivered at the right time for the right duration, at the right site of care.

Cigna works with eviCore healthcare to provide high-quality, cost-effective services to Cigna customers for outpatient, nonemergency, high-technology radiology and diagnostic cardiology services. Effective
1/1/2020 Cigna Medicare will require pre-certification from eviCore healthcare. Services performed without pre-certification may be denied for payment, and you may not seek reimbursement from members.

**General Program Information**

1.) Pre-certification applies to services that are:
   - Outpatient
   - Elective / Non-emergent
   - High-Technology Radiology
   - Diagnostic Cardiology

2.) Pre-certification **does not apply** to services that are performed in:
   - Emergency room
   - Inpatient
   - 23-hour observation

*It is the responsibility of the ordering provider to request pre-certification for services*

*It is the responsibility of the performing facility or provider to confirm pre-certification has been obtained and approved prior to service(s) being performed.*

Clinical Guidelines can be located by visiting: [https://www.evicore.com/cigna](https://www.evicore.com/cigna)

A list of Cigna Medicare CPT Codes that require pre-certification can be located by visiting: [www.eviCore.com/healthplan/healthspring](http://www.eviCore.com/healthplan/healthspring)

**Applicable Membership**

1.) Pre-certification will be required for the following membership:
   - Medicare

**Authorization Request Methods**

1.) The eviCore web portal is the fastest, easiest, most efficient way to obtain pre-certification and is available 24/7. Providers may access the eviCore provider portal by visiting [www.eviCore.com](http://www.eviCore.com)

Any questions and/or concerns regarding the web portal should be directed to Web Support by calling 1 (800) 646-0418, option 2 or by emailing Portal.Support@evicore.com

2.) The eviCore call centers are available from 7 a.m. to 7 p.m. based on local times.

Providers can call eviCore at 1 (888) 693-3211 to perform the following:
   - Request pre-certification
   - Check Status (Including Fax and Web initiated cases)
   - Provide additional clinical information

3.) Providers also have the option to fax pre-certification requests with the appropriate request forms that can be found at [www.evicore.com](http://www.evicore.com). These requests can be submitted by faxing to 1 (888) 693-3210

**To request pre-certification for urgent requests** providers can call 1 (888) 693-3211

**Information needed to submit for precertification**

1.) Member
   - Member ID
• Member Name
• Date of birth (DOB)

2.) Referring Physician
• Physician Name
• National provider identifier (NPI)
• Tax identification number (TIN)
• Fax Number

3.) Rendering Facility
• Facility name
• National provider identifier (NPI)
• Tax identification number (TIN)
• Street Address

4.) Supporting Clinical
• Patient's clinical presentation
• Prior tests, lab work, and/or imaging studies performed related to this diagnosis
• Notes from customers last visit related to the diagnosis
• Type and duration of treatment performed to date for the diagnosis

Clinical information is essential when requesting pre-certification through eviCore healthcare. All clinical information provided will help eviCore determine medical necessity. If clinical information is needed, please be able to supply:

**Decision Turn-Around Times**

1.) Non-Urgent decisions are typically made within two business days. All decisions are made within five business days.
2.) Urgent decisions will be made no later than 72 hours after the request is received.

**Medical Health Services**

**Overview**

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

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

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

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

Departmental Functions

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

Prior Authorization

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

Please refer to the 2020 Authorization requirements located here on CignaforHCP.com. Search for specific guidelines using the CPT codes along with https://www.cms.gov/ to check for covered services and procedure codes valid for Medicare.

If you are uncertain about the precertification requirement for a specific procedure, you may outreach to:

- Provider Service Department from 7 a.m. - 6 p.m. 1-800-882-4462 and follow the prompt to prior-authorization
- Fax, Attention AZ Medicare 1-866-730-1896.

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

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

Contact patient service to verify benefits, coverage, and patient eligibility. Authorization requests may be submitted by mail, phone, or fax (for limited services). After confirming eligibility and the availability of benefits, providers should submit all supporting documentation with the organization determination request via - fax or phone. Contact information for phone is: 1-800-882-4462

Phone lines are staffed Monday through Friday between the hours of 8:30 a.m. and 5:00 p.m.

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

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

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

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

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

In order to provide optimal service to our providers and customers, submission of clinical information at the time of the request is essential. Cigna may outreach to you for necessary information in order to make a determination. Requests received without supporting documentation may experience delays in processing up to the regulatory timeframes as CMS rules require that appropriate information be requested before decisions are rendered. See below for details regarding decision and notification timeframes.
For customers who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

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

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

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

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

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

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

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

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

Prior Authorization Requests and Time Frames
Emergency
An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average 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 patient’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 patient's health condition requires.

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

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

**Routine**

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

**Denial or Adverse Organization Determination**

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

**Retrospective Review**

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

- Authorizations for claims billed to an incorrect carrier.
  - As long as you have not billed the claim to Cigna and received a denial, you can request a retro authorization from Health Services within 2 business days of receiving the RA from the incorrect carrier.
  - If the claim has already been submitted to Cigna and you have received a denial, the request for retro authorization then becomes an Appeal and you must follow the guidelines for submitting an Appeal.
- Cigna will retrospectively review any medically necessary services provided to Cigna customers after hours, holidays, or weekends. Cigna does require the retro authorization request and applicable
clinical information to be submitted to the Health Services department within 1 business day of the start of care.

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

**Drugs/Biologics Part B (Medical Benefit)**

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

Convenient ways to obtain precertification:

- By calling the Drugs/Biologics Part B Precertification department at 1-888-454-0013.
- By faxing the Drugs/Biologics Part B Precertification department at 1-877-730-3858.

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

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

**Home Health Services**

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

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

It is the Home Health Provider’s responsibility to issue the written Notice of Medicare Non-Coverage (NOMNC) in accordance with CMS guidelines when a discharge from care is anticipated. Cigna validates the appropriate receipt of the NOMNC in accordance with CMS guidelines. Cigna will issue a NOMNC to the home health provider when an adverse determination is rendered. The home health provider is responsible for delivering the notice to the customer or their authorized representative/power of attorney.
(POA) at least 2 calendar days prior to the end date of the currently approved authorization. For services less than 2 calendar days in duration the provider is responsible to issue the NOMNC on the initial visit. A NOMNC must be delivered even if the customer agrees with the termination of services. The provider is responsible for ensuring the patient, authorized representative or POA signs the notice within the specified time frame. The NOMNC includes information on patient’s rights to file a fast track Appeal. If the provider believes continued home health care is required, a request for additional services must be submitted prior to the expiration of the existing authorization.

The home health provider is required to send a copy of the signed NOMNC back to Cigna promptly in order to ensure the patient’s rights to file a fast track Appeal are preserved. Receipt of the NOMNC will be monitored.

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

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

Cigna requires admission notification for the following:

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

Emergent or urgent admission notification must be received within twenty-four (24) hours of admission or next business day, whichever is later, even when the admission was prescheduled. If the patient’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 Health Services department complies with individual facility contract requirements for Concurrent Review decisions and timeframes. Cigna’s nurses, utilizing CMS guidelines and nationally accepted, evidence-based review criteria, will conduct medical necessity review. Cigna is responsible for final authorization.
Cigna’s preferred method for Concurrent Review is a live dialogue between our Concurrent Review nursing staff and the facility’s UM staff within 24 hours of notification or on the last covered day. If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information Cigna has available. If it is not feasible for the facility to contact Cigna via phone, facilities may fax the patient’s clinical information within 24 hours of notification to:

1-866-730-1896

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

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

**SNF Notice of Medicare Non-Coverage (NOMNC)**

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

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

The skilled nursing provider is required to send a copy of the signed NOMNC back to Cigna promptly in order to ensure the patient’s rights to file a fast track Appeal are preserved. Receipt of the NOMNC will be monitored.
For customers receiving hospital care and for those who transfer to a Skilled Nursing Facility or Acute Inpatient Rehabilitation Care, Cigna will approve the request or issue a notice of denial if the request is not medically necessary. Cigna will also issue a notice of denial if a customer who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the patient's or their representative’s right to file an expedited appeal, as well as instructions on how to do so if the customer or patient's physician does not believe the denial is appropriate.

Readmission
The Health Services Department will review all readmissions occurring within 31 days following discharge from the same facility, according to established processes, to assure services are medically reasonable and necessary, with the goal of high quality cost effective health care services for health plan customers. The Health Services Utilization Management (UM) staff will review acute Inpatient and Observation readmissions. If admissions are determined to be related, they may follow the established processes to combine the two confinements.

Adverse Determinations- Concurrent Review

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

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

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

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

- **For non-urgent pre-service/standard decisions** - within 14 calendar days of the request.
- **For urgent pre-service/expedited decisions** - *within 72 hours of receipt of the request.
- **For urgent concurrent decisions** - *within 24 hours of the request.
- **For post-service decisions** - within 30 calendar days of the request.
Cigna complies with CMS requirements for written notifications to customers, including rights to appeal and grievances.

**Discharge Planning and Acute Care Management (ACCM)**

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

**Outpatient Observation Notice**

Contracted hospitals and Critical Access Hospitals (CAHs) must implement the provisions of the NOTICE Act. Under the NOTICE Act, hospitals and CAHs must deliver the Medicare Outpatient Observation Notice (MOON) to any customer who receives observation services as outpatient for more than 24 hours. Details for the NOTICE Act Requirements can be located at: https://www.federalregister.gov/articles/2016/08/22/2016-18476/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-etc

**Emergency or Disaster Situations**

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

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

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

- Waives authorizations and referrals in full and does not require them customers in the affected counties for Medicare covered benefits.
- Temporarily reduces plan-approved out-of-network cost-sharing to in-network cost-sharing amounts;
- Waives the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee;
• Allows Part A and Part B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A and Part B benefits must, per 42 CFR § 422.204(b) (3), be furnished at Medicare certified facilities).

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

Cigna maintains the above in effect until the declaration is lifted or it expires. If no further notice is received, declarations expire 30 days from the effective date.

Referrals

HMO Referral Process

All plans require referrals to specialists in Arizona.

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<tr>
<th>Market</th>
<th>Product Offering</th>
<th>Specialist Referrals are required for this HMO plan</th>
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Overview
The Primary Care Physician (PCP) is the customer’s primary point of entry into the health care delivery system for all outpatient specialist care. The PCP must issue a referral for most outpatient specialist visits for Cigna customers. If you have questions on referral requirements, please contact Provider Customer Service at 1-800-627-7534.

Requesting a Referral
Referrals can be requested through these methods:

• Fax
• Phone
• Mail

Specialists are required to ensure that a referral is in place prior to scheduling a visit (except urgent/emergent visits, which do not require referral). The specialist is also required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment and the need for any ongoing care.

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

**Remember:** An authorization number does not guarantee payment – services must be a covered benefit. To verify benefits before providing services, call 1-800-627-7534.

**Referral Guidelines**

- PCPs should refer only to Cigna participating specialists within the appropriate network
- Non-participating specialists visits require Prior Authorization by Cigna
- Referrals must be obtained prior to specialist services being rendered
- PCPs should not issue retroactive referrals
- All requests for referrals must include the following information:
  - Customer name, date of birth, customer ID
  - PCP name
  - Specialist name
  - Date of referral
  - Service requested and diagnosis
  - Number of visits requested and timeframe valid (example: 3 visits and 3 months)

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

**Referrals to Non-Participating Providers**

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

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

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

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

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

How to Use Services
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. If you would like to refer a Cigna customer for care management/care coordinator services, please submit a referral to PHMReferrals@cigna.com or call our Provider Support line at 1-602-282-9662

In addition, our customers have access to information regarding the program via a brochure and website and may self-refer. Our case management staff contacts customers by telephone or in a face-to-face encounter. 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 patient’s access to a contracted network of facilities, primary care and specialty care physicians, behavioral health, and alcohol and substance use disorder specialists, as well an ancillary care network. Each customer receives a provider directory annually giving in-depth information about how to find network providers in their area (by zip code and by specialty), how to select a PCP (if required), conditions under which out-of-area and out-of-network providers may be seen, and procedures for when the patient’s provider leaves the network. A toll-free Customer Service telephone number is provided, and customers with questions are asked to reach out to the plan. Our website allows customers to search the provider directory for doctors, facilities, and pharmacies.

Our case management staff will work with you and your staff to meet the unique needs of each patient. Case managers work with customers and providers to schedule and prepare for customer visits, to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any non-clinical barriers to care. In cases where provider referrals are necessitated, case managers work closely with customers to identify appropriate providers, schedule visits, and secure transportation. The plan also has a provider incentive program that supports case management objectives and which incentivizes providers to coordinate closely with the customer and plan on specified quality measures.

Program Evaluation

Cigna continually monitors the program, and makes changes as needed to its structure, content, methods, and staffing. Changes to the program are made under two conditions: (1) changes must benefit customers; and (2) changes must be in compliance with applicable regulations and guidance. Changes to the program are accompanied by policy and procedure revisions and staff training as required. The program operates under the umbrella of the plan’s Quality Improvement Committee which reports to the Corporate Quality Improvement Committee. It is reviewed and updated annually in collaboration with the Quality Improvement Department. The plan’s Physician Advisory Committee made up of network providers, also reviews the program and it’s Clinical Practice Guidelines at certain intervals and provides improvement recommendations.

Continuity of Care

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

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

An active course of treatment is when a customer has regular visits with the provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or 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 the organizations UM policies and procedures.
• Charge only the required copayment.

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

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

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

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

Quality Programs

Quality Improvement Organization Program Changes
Under the direction of the Centers for Medicare and Medicaid Services the Quality Improvement Organization (QIO) program to improve the quality of care and health outcomes delivered to individuals with Medicare the BFCC-QIO contactors will focus on conducting quality of care reviews, discharge and termination of service appeals, and other areas of required review.

The BFCC-QIO contractor is:
Quality Care Management Program

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

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

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

Quality Principles
Cigna shall apply the guiding values described above to its oversight and operation of its system 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, the Senior Segment of Cigna and through our provider partners

• Promote customer safety as an over-riding consideration in decision-making

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

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

**Program Scope**

**The scope of the program includes:**

- All aspects of physical and behavioral care including accessibility, availability, level of care, continuity, appropriateness, timeliness and clinical effectiveness of care and services provided through Cigna and contracted providers and organization

- All aspects of provider performance relating to access to care, quality of care including provider credentialing, confidentiality, medical record keeping and fiscal and billing activities

- All covered services

- All professional and institutional care in all settings including hospitals, skilled nursing facilities, outpatient and home health

- All providers and any delegated or subcontracted providers

- Management of behavioral health care and substance use disorder care and services

- Aspects of Cigna internal administrative processes which are related to service and quality of care including credentialing, quality improvement, pharmacy, health education, health risk assessments, Clinical Practice Guidelines, Utilization Management, customer safety, case management, disease management, special needs, complaints, grievances and Appeals, customer service, provider network, provider education, medical records, customer outreach, claims payment and information systems.

**Quality Management Program Goals**

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

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

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

**Corporate Quality Improvement Committee (CQIC)**

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

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

**Health Care Plan Effectiveness Data and Information Set (HEDIS)**

HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) and medical record review data. HEDIS measurements include 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 and represent a mandated activity for health plans contracting with the Centers for Medicare and Medicaid Services (CMS). Each spring, Cigna
Representatives are required to collect from practitioner offices copies of medical records to establish HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections.

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

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

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

**Centers for Medicare & Medicaid Services 5-Star Rating System**

The Centers for Medicare & Medicaid Services (CMS) uses the 5-Star Quality Rating System to determine how much to compensate Medicare Advantage plans and educate consumers on health plan quality. The Star Ratings system consists of over 50 measures from five different rating systems.

The cumulative results of these measures make up the Star Rating assigned to each health plan. Star Ratings have a significant impact on the financial outcome of Medicare Advantage health plans by directly influencing the bonus payments and rebate percentages received. CMS will award quality-based bonus payments to high performing health plans based on their Star Ratings performance. For health plans with a four star or higher rating, a bonus payment is paid in the form of a percentage (maximum of five percent) added to the county benchmark. [A county benchmark is the amount CMS expects it to cost to provide hospital and medical insurance in the state and county.] After 2015, any health plans with Star Ratings below four will no longer receive bonus payments.

**Star Rating Components**

The Star Rating is comprised of over 47 different measures from five different rating systems:

**Star Rating System:**

- **HEDIS** - The Healthcare Effectiveness Data and Information Set is a set of performance measures developed for the managed care industry. All claims are processed regularly to extract the NCQA (National Committee for Quality Assurance) defined measures. For example, this allows the health plan and CMS to determine how many enrollees have been screened for high blood pressure.

- **CAHPS** - Consumer Assessment of Healthcare Providers and Systems is a series of patient surveys rating healthcare experiences that is performed on behalf of CMS by an approved vendor.

- **CMS** - Centers for Medicare & Medicaid Services rates each plan on administrative metrics, such as, beneficiary access, complaints, call center hold times and percentage of customers choosing to leave a plan.

- **PDE** - Prescription Drug Events is data collected on various medication-related events, such as high-risk medications, adherence for chronic conditions and pricing.

- **HOS** - Health Outcomes Survey is a survey that uses patient-reported outcomes over a 2.5-year time
span to measure health plan performance. Each spring a random sample of Medicare beneficiaries is
drawn from each participating Medicare Advantage Organization (MAO) that has a minimum of 500
enrollees and is surveyed. Two years later, these same respondents are surveyed again (i.e., follow up
measurement).

- IRE - Medicare Advantage plans are required to submit all denied enrollee appeals (Reconsiderations)
to an Independent Review Entity (MAXIMUS Federal Services).

These systems rate the plans based on five domains:
(1) Staying Healthy: Screenings, Tests and Vaccines
(2) Managing Chronic (Long Term) Conditions
(3) Customer Experience with Health Plan
(4) Customer Complaints, Problems Getting Services, and Improvement in the Health Plan’s Performance
(5) Health Plan Customer Service
(6) Data used to calculate the ratings comes from surveys, observation, claims data and medical records

CMS continues to evolve the Star Ratings system by adding, removing and adjusting various measures on
a yearly basis. CMS weights each measure between one and three points. A three-point measure, or triple
weighted measure, is one that CMS finds most important and should be a focus for health plans.

The composition of all rating systems is indicated below. The Patient Protection and Affordable Care Act
(PPACA) requires that Medicare Advantage plans be awarded quality-based bonus payments beginning in
2012, as measured by the Star Ratings system. Bonus payments are provided to MA plans that receive
four or more stars. CMS assigns a benchmark amount to each county within a state, which is the
maximum amount CMS will pay to provide hospital and medical benefits. All MA plans submit a bid, which
is the projected cost to operate MA within the county. The spread between the bid and original benchmark
is called the rebate. A bonus payment is the percentage added to the county benchmark, which increases
the spread and the amount of revenue received by the health plan.

Special Needs Plans (SNP MOC)

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

**Special Needs Plan Eligibility Criteria**

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

The three SNP specific groups are:

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

Cigna offers the three SNP types described above.

**SNP Model of Care:**

CMS mandates that each SNP type have a Model of Care (MOC). The MOC is an evidenced-based care management program which facilitates the early and on-going assessments, the identification of health risks and major changes in the health status of SNP customers. The SNP MOC provides structure and describes the coordination of care and benefits and services targeted to improve the overall health of our SNP customers. The MOC also serves to ensure that the unique needs of our SNP customers are identified and appropriately addressed.

The SNP MOC identifies four key care management components:

1. SNP population – provides a description of the unique characteristics of our overall and most vulnerable SNP customers.
2. Care coordination – describes our SNP staff structure, the Health Risk Assessment (HRA), Individualized Care plan (ICP), Interdisciplinary Care Team (ICT) and Care Transition process, all of which identify the services and benefits offered through this plan and are available to our SNP customers. The wide range of services is targeted to help our SNP customers achieve their optimal health and improve the connection to care
3. Provider Network – describes the Specialized Expertise providers who participate in our SNP program, Clinical Practices guidelines, and Care Transition protocols. The SNP MOC Training is also addressed this section.

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

4. MOC Quality Measurement and Performance Improvement –describes the quality improvement plan and identifies goals for the SNP population; this section of the MOC includes clinical and customer satisfaction goals, as well as on-going performance evaluation of the SNP MOC.
SNP MOC Process
The Cigna SNP MOC care management process focuses on the unique needs of our SNP customers with the goal of identifying interventions, care coordination and care transition needs, barrier to care, education, early detection, and symptom management.

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

- Health Risk Assessment (HRA) – Cigna will conduct an HRA to identify care needs. SNP customers will have a Health Risk Assessment (HRA) completed within 90 days of enrollment and then annually, within 365 days of the last HRA.

- Individualized Care Plan (ICP) – HRA results and evidence-based clinical protocols are utilized to develop an ICP. The Interdisciplinary Care Team is responsible for the development of an ICP.

- Interdisciplinary Care Team – An ICT is composed of key stakeholders, including the PCP and case managers. The ICT help to develop the ICP.
  o Primary Care Providers (PCPs) who treat SNP customers are core participants of the Interdisciplinary Care Team (ICT) as they are the primary care giver. However, ICT participants can also include practitioners of various disciplines and specialties, based on the patient’s individual needs. The customer may participate in the ICT meetings, as may health care providers.

- Care Transition – a change in health status could result in new care management needs. As a result, our case management teams provide support to address the specific needs of our SNP population.
  o As a provider, your participation is required for the coordination of care, care plan management and in identifying additional health care needs for our Special Needs program customers.

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

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

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

Implementation of the SNP Model of Care is supported through feedback from you, as well as systems and information sharing between the health plan, health care providers and the patient. The SNP Model of Care includes periodic analysis of effectiveness, and all activities are supported by the Stars & Quality department.
SNP Contact Information
When a SNP customer completes a Health Risk Assessment (HRA), a care plan is generated. A copy of the HRA can be obtained by calling our Population Health Management department at 602-282-9662 or sending an email to PHMReferrals@Cigna.com.

The customer and assigned PCP will receive a copy of the patient's care plan. A copy of the HRA can be obtained by calling our Population Health Management department at 602-282-9662 or by sending an email to PHMReferrals@Cigna.com.

To discuss and/or request a copy of the care plan, refer a SNP customer for an Interdisciplinary Care Team meeting or to participate in an Interdisciplinary Care Team meeting, please contact our Case Management department by calling 602-282-9662

Pharmacy

Pharmacy Prescription Benefit

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

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

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

- May be dispensed only by prescription
- Approved by the FDA
- Used and sold in the US
- Used for a medically accepted indication
  - Includes both the uses approved by the FDA and off-label uses supported by medical compendia as approved by the Social Security Act (SSA)
  - Except for anticancer chemotherapy, the current compendia allowed per CMS include 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
For anticancer chemotherapy, additional sources are available beyond FDA package label, Micromedex, and AHFS-DI. These include National Comprehensive Cancer Network (NCCN), Clinical Pharmacology, and Lexicomp, as well as some use of peer-reviewed literature.

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

**Part D Utilization Management**

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

**Prior Authorization (PA)**

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

For Prior Authorization Requests please use: [http://www.covermymeds.com](http://www.covermymeds.com)

Or call **800-244-6224** Step Therapy (ST)

For a select group of drugs, Cigna requires the customer to first try and fail certain drugs/drug classes to treat their medical condition before covering another drug for that condition.
Quantity Limits (QL)
For a select group of drugs, Cigna limits the amount of the drug that will be covered without prior approval.

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

Electronic prior authorization (ePA) is Cigna’s preferred way to receive a coverage determination requests, to create a free account, visit https://www.covermymeds.com/main

For the provider call center, please call: 1-877-813-5595 7 a.m. to 8 p.m. CST Monday through Friday or fax: 1-866-845-7267

The address is:
Coverage Determination and Exceptions
PO Box 20002
Nashville, TN 37202.

Any call received after 8 p.m. CST will be routed to a voicemail box and processed daily. To ensure timely review of a CD and that the prescriber is aware of what Cigna requires for the most commonly requested drugs, drug-specific CD forms are available here or by requesting a faxed copy when calling 1-877-813-5595.

For standard requests, the provider will receive the outcome of a coverage determination via phone, fax or USPS mail no later than seventy-two (72) hours after the initial request receipt or receipt of the supporting statement, and for urgent requests, the provider will receive the outcome notification no later than twenty-four (24) hours after the initial request receipt or receipt of the supporting statement. The following information will be provided:

1. The specific reason for the denial taking into account the patient’s medical condition, disabilities and special language requirements, if any;
2. Information regarding the right to appoint a representative to file an Appeal on the patient’s behalf; and
3. A description of both the standard and expedited redetermination processes and timeframes including conditions for obtaining an expedited redetermination and the appeals process. The fax cover sheet includes the peer-to-peer process if a provider has questions and wants to review with a clinical pharmacist.

How to File a Part D Appeal
A Part D appeal, or redetermination, must be filed within 60 calendar days from the date printed/written on the coverage determination denial note. For a standard Part D appeal, Cigna will provide a decision and written notice no later than seven (7) calendar days from the date the request was received. For an expedited/urgent Part D appeal, Cigna will provide a decision no later than seventy-two (72) hours after receiving the appeal. Requestors may request an expedited appeal in situations where applying the
standard time frame could seriously jeopardize the patient’s life, health or ability to regain maximum function. If the request is regarding payment for a prescription drug the customer already received, an expedited appeal is not permitted.

Part D appeals may be received orally or in writing from a patient, patient’s representative, patient’s prescribing physician or other physician.

Part D Appeals Contact Information:

Phone: 1-866-845-6962
Fax: 1-866-593-4482

Mailing Address:
Part D Appeals
PO Box 24207
Nashville, TN 37202–9910

Pharmacy Networks

Pharmacy Network
Cigna provides access to more than 64,000 network pharmacies throughout the country. This extensive network gives our customers – your customers – convenient access to many pharmacies in their area to choose for their unique pharmacy needs. Options range from large chain pharmacies to locally owned, independent retail pharmacies. Long-term care, home infusion, mail order, home delivery pharmacy options are available, as well.

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

Pharmacy Quality Programs

Narcotic Case Management
The Narcotic Case Management Program is designed to identify patterns of inappropriate opioid utilization with the goal to enhance customer safety through improved medication use. Monthly reports are generated using an algorithm that identifies customers at risk of potential opioid overutilization based on the number of prescribers, pharmacies, and calculated morphine milligram equivalent (MME) per day. Any individual
with cancer or on hospice care is excluded from the program. The Cigna clinical staff review claims data of all identified customers who meet the established criteria and determine whether further investigation with prescribers is warranted. If intervention is deemed appropriate, clinical staff will send written notification by fax to the prescribers involved in the patient’s care requesting information pertaining to the medical necessity and safety of the current opioid regimen. Cigna will reach out to discuss the case with the patient’s opioid prescriber(s) in an attempt to reach a consensus regarding the patient’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 patient-specific limitations to assist with control of inappropriate utilization or overutilization of opioid medications. The limitations may require customers to use only selected pharmacies or prescribers for opioid medications or limit the amount of opioid medication covered by the health plan. If Cigna does not receive a response from the prescribers, despite multiple outreach attempts, then limitations may be invoked based on the decision of an internal, multi-disciplinary team.

**Medication Therapy Management**

The Medication Therapy Management (MTM) program is designed to help improve medication therapy outcomes by identifying gaps in care, addressing medication adherence, and recognizing potential cost savings opportunities. The program is designed for customers that satisfy all three of the following criteria:

- Have at least three of the following conditions: Chronic Heart Failure (CHF), Diabetes, Dyslipidemia, Hypertension, and Osteoporosis
- Take at least seven Part D prescription drugs from select classes; and
- Are likely to incur annual costs for covered drugs greater than or equal to $4,255

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

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

There is no additional cost for participation in the MTM program. MTM Program CMR completion rate is a Part D Star rating based off the percentage of customers who meet eligibility criteria for MTM program and who receive a CMR. Refer eligible customers to the MTM program at 1-800-625-9432 to complete their annual CMR.
Drug Utilization Review
Cigna completes a monthly review of prescription drug claims data to assess dispensing and use of medications for our customers. Drug Utilization Review (DUR) is a structured and systematic attempt to identify potential issues with drug therapy coordination among prescribers, unintentional adverse drug events (including drug interactions), and non-adherence with drug regimens among targeted classes of drugs. Retrospective Drug Utilization Review (rDUR) evaluates past prescription drug claims data, and concurrent Drug Utilization Review (cDUR) ensures that a review of the prescribed drug therapy is performed before each prescription is dispensed. cDUR is typically performed at the point-of-sale, or point of distribution, by both the dispensing pharmacist and/or through automated checks that are integrated in the pharmacy claims processing system. Cigna tracks and trends all drug utilization data on a regular basis to enable our clinical staff to determine when some type of intervention may be warranted, whether it is patient-specific or at a population level. Targeted providers and/or customers identified based on DUR activity will receive information regarding the quality initiative by mail or fax. rDUR studies that may be communicated to customers and/or providers include:

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

Letters to customers will focus on topics such as the importance of appropriate medication adherence or safety issues. Letters to providers will include the rationale for any of the particular concerns listed above that are the subject of the initiative. Provider letters will also include drug claims data for the selected calendar period applicable to the initiative. If you (as a provider) receive a letter indicating that you prescribed a medication that you did not, in fact, prescribe, please notify Cigna using the contact information on the letter.

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

Important Opioid cDUR Changes for 2020
Opioid initiatives for 2020 focus on strategies to help prevent and combat opioid overuse among our beneficiaries through the use of cDUR. Safety controls will be implemented at point-of-sale, including “soft” and “hard” cDUR edits, which will both reject the claim. The dispensing pharmacy may override a “soft” rejection by entering the appropriate pharmacy professional service (PPS) codes upon consulting the prescriber and/or determining safe and appropriate use of the medication. “Hard” rejections may not be
overridden at point-of-sale, and in order to request coverage of the medication(s), a coverage determination must be initiated. Listed below are the opioid changes that will occur in 2020, which are in line with CMS guidance on required and recommended changes to utilization management of opioid prescriptions:

- Opioid prescriptions will be limited to a maximum of a 1-month supply OR a 7-day supply in opioid naïve customers. Cigna defines “opioid naïve” as customers who have not had an opioid medication filled within the past 120 days. This is a “hard” cDUR edit and will require a coverage determination for coverage under the beneficiary’s part D plan if a day supply exceeding these limits is needed.

- Opioid prescriptions for customers who have claims exceeding a total of 90 morphine milligram equivalents (MME) per day AND have 2 or more opioid prescribers will receive a “soft” rejection at point-of-sale. A coordination of care between the prescriber and dispensing pharmacist is encouraged. Upon consulting the prescriber and receiving approval, the dispensing pharmacist may use pharmacy professional service (PPS) codes to override the “soft” rejection.

- Opioid prescriptions will “soft” reject at point-of-sale if an interaction with a benzodiazepine is detected. The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides customer counseling, and/or determines that it is safe to dispense the medication(s).

- Opioid prescriptions for long-acting opioid medications will “soft” reject at point-of-sale if a duplication of therapy is detected between 2 or more long-acting opioid medications. The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides customer counseling, and/or determines that it is safe to dispense the opioid medication(s).

Prescription Drug Monitoring Programs

Prescription Drug Monitoring Programs Information
Nearly all states currently require pharmacies and other dispensers to submit records of certain prescription drugs dispensed on a daily to monthly basis. These data are compiled into state-run databases, termed prescription drug monitoring programs (PDMPs), and made available in a searchable format to prescribers and pharmacists for use in monitoring drug utilization and abuse.

In their landmark 2016 Guideline for Prescribing Opioids for Chronic Pain, the CDC features PDMPs prominently in their final recommendations:

*Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the customer is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.*

As part of our ongoing partnership with providers to decrease the unnecessary use and diversion of controlled substances, Cigna encourages prescribers and pharmacists to fully utilize their state’s PDMP. You may find your state’s PDMP at: [http://www.pdmpassist.org/content/state-pdmp-websites](http://www.pdmpassist.org/content/state-pdmp-websites).

MedWatch: The FDA Adverse Event Reporting Program
The Food & Drug Administration (FDA) MedWatch is a safety information and adverse event reporting program that allows both clinicians and consumers to report serious issues with human medical products and receive safety information updates. The FDA relies on clinicians to report medical adverse events after a drug product is marketed, as clinical trials may not elucidate all potential safety concerns for customers.

It is appropriate to report issues related to prescription and over-the-counter medications, biologics, medical devices, combination products, special nutritional products (infant formulas, medical foods), cosmetics, and foods/beverages to FDA’s MedWatch Adverse Event Reporting Program. Types of events to report include: serious adverse events, product quality problems, product use/medication errors, therapeutic inequivalence/failure, and counterfeit medical products. Clinicians may submit a report using Form 3500, available online at www.fda.gov/medwatch/report.htm, or by downloading and mailing (5600 Fishers Lane, Rockville, MD 20852-9787) or faxing the form (fax number 1-800-332-0178). Questions about the form can be answered at 1-800-332-1088.

Safety problems with tobacco, vaccines, investigational study drugs, veterinary products, and dietary supplement problems should not be reported to FDA MedWatch. Adverse events with vaccines can be reported through the Vaccines Adverse Event Reporting System (VAERS) at https://vaers.hhs.gov/reportevent.html. For additional information on where to submit adverse event reports for the other product types, visit https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home.

Voluntary adverse event reporting is critical to maintain FDA surveillance of product safety. One single report could prompt a product safety investigation that could result in product label updates, Medication Guide inclusion criteria, product recalls, and/or product design, process, packaging, or distribution changes. Additionally, subscribing to MedWatch Safety Alerts via Email (MedWatch E-list), Twitter (@FDAMedWatch), or RSS provides a consumer-friendly platform by which to easily stay updated with recent alerts, and in turn, help improve the overall care and safety of customers.

Low Income Subsidy Program Information

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

- Low or no monthly Part D premiums
- Low or no initial Part D deductible
- Coverage in the Donut Hole or Coverage Gap
- Greatly reduced costs for prescription drugs that are covered by the Medicare Part D plan and/or
- 90-day supply of Medicare Part D covered drugs for the same cost as a 30-day supply (applies to most but not all beneficiaries who qualify for Extra Help)
Eligibility
To be eligible for the Extra Help program individuals must reside in one of the 50 states or the District of Columbia and meet certain income and resource limits. Resources include items like savings, stocks and money in checking/savings accounts, but will not include an individual’s home or car. Income limits, set by the federal government, are used to determine eligibility for the Extra Help program and are based on the Federal Poverty Level (FPL) published by Department for Health & Human Services (DHHS).

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

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

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

Home Delivery Pharmacy

Home Delivery Pharmacies

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

Your customers can receive a three-month supply of their medications through mail order, making it easier for the customer as they only fill their script four times per year. Using preferred mail order will generally lower their costs, sometimes to as low as $0, and improve their adherence. Talk to your customers about home delivery.

We contract with approximately 64,000 network pharmacies throughout the country, including major retail pharmacy chains and independent pharmacies. A complete listing can be found on our website at the Pharmacy Network Page.

The Express Scripts Pharmacy (added July 2019)
- Customers should call Express Scripts at 1-877-860-0982 to enroll
- Express Scripts will reach out to the provider for the script

A complete listing can be found on our website at the Pharmacy Network page.
Provider Information

Primary Care and Specialist Responsibilities

Providers Designated as Primary Care Physicians (PCPs)
Cigna recognizes Family Medicine, General Practice, Geriatric Medicine, and Internal Medicine physicians as Primary Care Physicians (PCPs).

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

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

The Role of the Primary Care Physician (PCP)
Each Cigna Medicare Advantage customer must select a Cigna participating Primary Care Physician (PCP) at the time of enrollment. The PCP is responsible for managing all the health care needs of a Cigna customer as follows:

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

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

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

Administrative, Medical, and Reimbursement Policy Changes
From time to time, Cigna may amend, alter, or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards, and modification of Covered Services. Specific Cigna policies and procedures may be obtained by calling our Provider Services Department at 1-800-627-7534.

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

• Annual provider manual updates.
• Letter.
• Facsimile.
• Email.
• 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 any changes upon receipt of notice or otherwise becoming aware or informed of such changes.
Communication among Providers

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

Provider Marketing

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

Providers can:

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

Providers cannot:

• Urge or steer towards any specific plan or limited set of plans.
• Collect enrollment applications in physician offices or at other functions.
• Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
• Conduct health screenings to potential enrollees.
• Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
• Call customers who are dis-enrolling from the health plan to encourage re-enrollment in a health plan.
• Mail notifications of health plan sales meetings to customers.
• Call customers to invite customers to sales, and marketing activity of a health plan.
• Advertise using Cigna's name without Cigna’s prior consent.
• Issue advertisements that mention benefits without CMS approval.

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

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

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

If the patient's behavior cannot be remedied through reasonable efforts, and the PCP feels the relationship has been irreparably harmed, the PCP must submit in writing, to Network Operations, a customer transfer request.

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

**Procedure**

1. Once the physician has determined that the physician/customer relationship has been irreparably harmed, the physician should submit the completed Physician Notice to Discharge a Customer from Panel form to their Network Operations Representative and provide details and documentation to support their decision.

2. The physician is required to send the customer a notice informing them of their decision to terminate the physician/customer relationship. The notice must be sent to the customer at least 30 (calendar) days in advance of discharging a customer from a practice.

3. The physician is required to continue customer care for at least 30-45 days or longer to allow the customer time to select and be assigned a new PCP.

4. The physician will transfer, at no cost, a copy of the medical records of the customer to the new PCP and will cooperate with the patient's new PCP in regard to transitioning care and providing information regarding the patient's care needs.

A customer may also request a change in PCP for any reason. The PCP change that is requested by the customer will be effective the first (1st) of the month following the receipt of the request, unless circumstances require an immediate change.

**Provider Participation**

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

<table>
<thead>
<tr>
<th>PROVIDER: NEW TO PLAN AND NOT PREVIOUSLY CREDENTIALED</th>
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<tbody>
<tr>
<td><strong>Status</strong></td>
</tr>
<tr>
<td>Practicing in a solo practice</td>
</tr>
<tr>
<td>Joining a participating group practice</td>
</tr>
</tbody>
</table>
Physician Rights and Responsibilities

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

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

Physician Responsibilities

- You must treat Cigna customers the same as all other customers in your practice, regardless of the type or amount of reimbursement.
- Primary Care Physicians shall use best efforts to provide customer care to new customers within four (4) months of enrollment with Cigna.
- Primary Care Physicians shall use best efforts to provide follow-up customer care to customers that have been in the hospital setting within ten (10) days of hospital discharge.
- Primary Care Physicians are responsible for the coordination of routine preventive care along with any ancillary services that need to be rendered with authorization. (HMO)
- All providers are required to code to the highest level of specificity necessary to accurately and fully describe a patient’s acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.

### PROVIDER: ALREADY PARTICIPATING AND CREDENTIALED

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaving a group practice to begin a solo practice</td>
<td>Does not require credentialing; however a new contract is required and the previous group practice affiliation is terminated</td>
</tr>
<tr>
<td>Leaving a participating group practice to join another participating group practice</td>
<td>Does not require credentialing yet the group practice affiliation will be amended</td>
</tr>
<tr>
<td>Leaving a participating group practice to join a non-participating group practice</td>
<td>The provider's participation is terminated Credentialing is still valid until recredentialing due date</td>
</tr>
</tbody>
</table>
• Specialists must also provide continuous 24 hour, 7 days a week access to care for Cigna customers. (HMO)

• For HMO products, specialists must coordinate the referral process (i.e. obtain authorizations) for further care that they recommend. This responsibility does not revert back to the Primary Care Physician while the care of the customer is under the direction of the specialist.

• In the event you are temporarily unavailable or unable to provide customer care or referral services to a Cigna patient, you must arrange for another physician to provide such services on your behalf. This coverage cannot be provided by an Emergency Room.

• You must provide continuity of care upon termination in accordance with your contract.

• For HMO products, you must utilize Cigna’s participating physicians/facilities when services are available and can meet your patient’s needs. Approval prior to referring outside of the contracted network of providers may be required.

• You must participate in Cigna’s peer review activities as they relate to the Quality Management/Utilization Review program.

• You must cooperate with Cigna’s Quality Improvement (QI) activities to improve the quality of care and services and the customers’ experience.

• You must allow Cigna to use your performance data; including the collection, evaluation and use of data in the participation of QI programs.

• You must maintain customer information and records in a confidential and secure manner.

• As a practitioner or provider of care you affirm to freely and openly discuss with customers all available treatment options regardless of whether the services may be covered services under the patient’s benefit plan. This includes all treatment options available to them, including medication treatment options, regardless of benefit limitations.

• You may not balance bill a customer for providing services that are covered by Cigna. This excludes the collection of standard copays. You may bill a customer for a procedure that is not a covered benefit if you have followed the appropriate procedures outlined in the Claims section of this manual.

• All claims must be received within the timeframe specified in your contract.

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

Participating providers shall provide covered services in a culturally competent manner to all customers by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. Examples of how a provider can meet these requirements include but are not limited to: translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.
Cigna offers interpreter services and other accommodations for the hearing-impaired. Translator services are made available for non-English speaking or Limited English Proficient (LEP) customers. Providers can call Cigna customer service at **1-800-627-7534** to assist with translator and TTY services if these services are not available in their office location.

**Delegation**

Delegation is a formal process by which Cigna enters into a written contract with an entity to provide administrative or health care services for customers on Cigna’s behalf. A function may be fully or partially delegated. Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated. The decision of what function may be considered for delegation is determined by the type of participation agreement a provider group has with Cigna, as well as the ability of the provider group to perform the function. Contact the local Cigna provider representative for detailed information on delegation.

Although Cigna can delegate the authority to perform a function, it cannot delegate the responsibility.

Delegated providers must comply with the responsibilities outlined in their Delegated Services Agreement and Cigna policies and procedures.

**Customer Information**

**Programs and Services**

**Benefits and Services**

All Cigna customers receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, Cigna makes available to each participating Primary Care Physician a list of their active customers. Along with the patient’s demographic information, the list includes the name of the plan in which the customer enrolled. Please be aware that recently terminated customers may appear on the list. (See “Eligibility Verification” section of this manual).

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

**Emergency Services and Care After-Hours**

**Emergency Services**

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

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

In the event of a perceived emergency, customers have been instructed to first contact their Primary Care Physician for medical advice. However, if the situation is of such a nature that it is life threatening, customers have been instructed to go immediately to the nearest emergency room facility. 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 forty-eight (48) hours after receiving care. The PCP will be responsible for providing and arranging any necessary follow-up services.

For emergency services within the service area, the PCP is responsible for providing, directing, or authorizing a patient’s emergency care. The PCP or his/her designee must be available twenty-four (24) hours a day, seven days a week 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 Non-participating providers in accord with CMS requirements for emergency services rendered to members if they become injured or ill while temporarily outside the 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 patient’s unforeseen illness, injury, or condition, it was not reasonable given the circumstances to obtain the services through Cigna’s provider network, and the customer is either temporarily absent from Cigna’s service or continuation area or the Cigna provider network is temporarily unavailable or inaccessible. The customer must first attempt to receive care from his/her PCP. Treatment at a participating Urgent Care Center will be covered by Cigna without a referral.

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

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

Appeal Process
All telephonic inquiries received by Cigna Medicare Advantage Customer Service Department will be resolved on an informal basis, except for inquiries that involve “Appealable” issues. Appealable issues will be routed through either the standard or expedited appeal process. A pre-service expedited appeal is processed within 72 hours of receipt for situations where waiting longer for a response could result in
serious health consequences. Standard pre-service appeals are resolved within 30 days of receipt for services not yet received. Prior to requesting an Expedited Appeal, providers must immediately fax all pertinent Medical Records or be available within the 72 hours timeframe to provide applicable clinical information to support the request for appeal.

Standard Appeals will be responded to within 60 days for services that have been provided.

**Written appeals can be mailed or sent via FAX and should be sent to:**

**Appeals and Grievances**  
PO Box 29030  
Phoenix, AZ 85038  
Or  
FAX: 1-866-567-2474

Cigna customers and providers have the right to appeal any decision about Cigna's failure to provide what they believe are benefits contained in the basic benefit package. These include:

- Reimbursement for urgently needed care outside of the service area or Emergency Services worldwide.
- A denied claim for any health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by Cigna.
- Services not received, but believed to be the responsibility of Cigna.
- A reduction or termination of a service a customer feels is medically necessary.

In addition, a customer may Appeal any decision related to a hospital discharge. In this case, a notice will be given to the customer with instructions for filing an Appeal. The customer will remain in the hospital while the Appeal documentation is reviewed. The customer will not be held liable for charges incurred during this period, regardless of the outcome of the review. Please refer to the Cigna Evidence of Coverage (EOC) for additional benefit information.

**Grievance Process**

Cigna customers have the right to file a complaint, also referred to as a grievance, regarding any problems they observe or experience with the health plan or a contracted provider.

Situations for which a grievance may be filed include but are not limited to:

- Dissatisfaction with the office experience such as physician or office staff behavior or demeanor
- Receiving incorrect charges or co-pays, balance billing (Reference Dual Eligible Section). This includes situations when a customer is not properly informed of co-pays or deductibles before receiving treatment. Refer customers to contact the Customer Service number listed on their ID card for information on covered services.
- Excessive wait times in office (office wait time, check-in or check-out times exceed 30 minutes). Refer to the Access and Availability Requirements section.
• Inadequate office space or facilities. This includes waiting and examining room space, physical appearance and cleanliness of facility.
• Inability to reach or contact the provider or office staff via phone (i.e. unable to reach physician during regular business hours, excessive hold times, continuous busy signal, inability to leave a voicemail, not receiving a return call after leaving numerous voicemails.)
• Lack of appointment availability (Refer to the Access and Availability Requirements Section)
• Physician discharge of customer from practice without proper advanced notice.
• Inability to obtain a timely referral from provider.
• Poor quality of care or services received.

All customers have the right to be treated with respect and receive timely and adequate necessary services. If a grievance is received against you, one of your providers, your practice or facility, a Network Operations Representative will contact you to resolve the issue. Providers must comply with Cigna’s procedures for customer grievances, organization determinations, and customer appeals set forth in the Benefit Program Requirements for Benefit Programs under the Medicare Advantage Program. Grievances are monitored by Cigna, excessive grievances received may result in a formal discussion, office site visit and assessment, corrective action plans and can lead up to termination.

If customers need help with communication, such as help from a language interpreter, they should be directed to call Customer Service. Customer Service can also help customers file complaints about access to facilities (such as wheel chair access). Call toll free: 1-800-627-7534

**Maximum Out-Of-Pocket (MOOP)**

The Maximum Out-of-Pocket (MOOP) is a limit on the amount customers are required to pay out-of-pocket each year for medical services which are covered under Medicare Part A and Part B. Once the MOOP expense is reached, the customer is no longer responsible for any out-of-pocket expenses, including any cost shares, for the remainder of the year for covered Part A and Part B services (excluding the patient’s Medicare Part B premium and Cigna plan premium).

**Customer Confidentiality**

Cigna does not disclose customer information to anyone without obtaining consent from an authorized person(s) or unless we are specifically authorized to so do by law. Because you are a valued provider to Cigna, we want you to know the steps we have taken to protect the privacy of our customers. This includes how we gather and use their personal information. Cigna’s privacy practices apply to all of our past, present, and future customers.

When a customer joins a Cigna Medicare Advantage plan, the customer agrees to give Cigna access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual,
or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium.

Access to PHI allows Cigna to work with providers, like yourself, to decide whether a service is a covered service and pay your clean claims for covered services using the customers’ medical records. Medical records and claims are generally used to review treatment and to conduct quality assurance activities but they also allow Cigna to look at how care is delivered and carry out programs to improve the quality of care Cigna’s customers receive. This information also helps Cigna manage the treatment of diseases to improve our customers’ quality of life.

Cigna’s customers have additional rights over their health information. They have the right to (but, not limited to the following):

- Send Cigna a written request to see or get a copy of information about them, or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer Cigna’s customer to the source of the information.
- Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.
- Receive an accounting of Cigna’s disclosures of their medical information, except when those disclosures are for treatment, payment, or health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect patient PHI. To discuss any known or suspected breaches of the privacy of our customers, please immediately contact our HIPAA Privacy Officer at 1-860-787-6801.

Patient Rights and Responsibilities

Patient Rights
Cigna customers have certain rights of which participating providers must be aware:

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

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

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

The right to see participating providers, get covered services, and get prescriptions filled within a reasonable period of time
Customers will get most or all of their health care from participating providers, that is, from doctors and other health providers who are part of Cigna’s provider network. Customers have the right to choose a participating provider (Cigna will work with customers to ensure they find physicians who are accepting new customers).
Customers have the right to go to a women’s health specialist (such as a gynecologist) without a referral Reminder – applicable to HMO. Refer to authorization section of this manual for additional guidance.

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

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. Customers must be told in advance if any
proposed medical care or treatment is part of a research experiment and be given the choice to refuse experimental treatments.

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

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

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

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

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

The right to receive more information about customers’ rights
Customers have the right to receive information about their rights and responsibilities. If customers have questions or concerns about their rights and protections, they should be directed to call Customer Service. Customers can also get free help and information from their State Health Insurance Assistance Program (SHIP). Additionally, customers can obtain a free copy of the Customer Medicare Rights and Protections booklet by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Customers
can call 24 hours a day, 7 days a week, or customers can visit www.medicare.gov to order this booklet or print it directly from their computer.

The right to take action if a customer thinks they have been treated unfairly or their rights are not being respected
If customers think they have been treated unfairly or their rights have not been respected, there are options for what they can do.

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

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

Customers are responsible for the following:

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

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

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

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

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

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

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**Policies**

**Corporate Compliance Program**

**Overview**

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

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

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

**Fraud, Waste, and Abuse**

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

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

To report potential fraud, waste, or abuse please contact Cigna’s Special Investigations Unit:

By mail:
Cigna
Attn: Special Investigations Unit
PO Box 20002
Nashville, TN 37202

By email: [specialinvestigations@cigna.com](mailto:specialinvestigations@cigna.com)

By phone: **1-800-230-6138**.

Monday through Friday, 8 a.m. to 5 p.m. CST

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.

In addition, as part of an ongoing effort to improve the delivery and affordability of health care to our customers, Cigna conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9 and HCPCS, codes billed by our providers. The analysis allows Cigna to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. Cigna will review your coding and may review medical records of providers who continue to show significant variance from their peers. Cigna strives to
ensure compliance and enhance the quality of claims data, a benefit to both Cigna’s medical management efforts and our provider community. As a result, you may be contacted by Cigna’s contracted partners to provide medical records to conduct reviews to substantiate coding and billing.

**Steps to Meet Your FWA Obligations**

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

Complete the mandatory online training at:


- **Web-Based Training (WBT) course**: Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training.

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

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

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

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

Patient Hold Harmless
Participating providers are prohibited from balance billing Cigna customers including, but not limited to, situations involving non-payment by Cigna, insolvency of Cigna, or Cigna’s breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than Cigna, acting on behalf of customers for Covered Services provided pursuant to the Participating Provider’s Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances or deductibles for covered services in accordance with the terms of the applicable patient’s Benefit Plan, or for collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of the provider manual.

Non-Covered Services
Providers may only collect fees from customers for non-covered services when the customer has been provided with a standardized written Organization Determination (OD) denial notice from Cigna prior to the item or service being rendered to the patient, or if the patient’s EOC clearly states the item or service is a non-covered service.
In circumstances where there is a question whether or not the plan will cover an item or service, customers have the right to request an OD prior to obtaining the service from the provider. If coverage is denied, Cigna provides the customer with a standardized written OD denial notice which states the specific reasons for the denial and informs the customer of his or her appeal rights. In absence of the appropriate Cigna OD denial notice or a clear exclusion in the EOC, the customer must be held harmless (i.e., cannot be held financially liable for the charges).

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

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

**Delegation of Activities or Responsibilities**

To the extent activities or responsibilities under a CMS Contract are delegated to provider pursuant to the Agreement (“Delegated Activities”), provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Cigna; and (ii) in the event that the Cigna or CMS determine that provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable state and/or federal laws and regulations and CMS instructions, then Cigna shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Cigna. To the extent that the Delegated Activities include professional credentialing services, provider agrees that the credentials of medical professionals affiliated or contracted with provider will either be (i) directly reviewed by Cigna, or (ii) provider’s credentialing process will be reviewed and approved by Cigna and Cigna shall audit provider’s credentialing process on an ongoing basis. Provider acknowledges that Cigna retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals. In addition, provider understands and agrees that Cigna maintains ultimate accountability under its Medicare Advantage contract with CMS. Nothing in this Agreement shall be construed to in any way limit Cigna’s authority or responsibility to comply with applicable regulatory requirements.

**Compliance with Cigna’s Obligations, Provider Manual, Policies and Procedures**

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

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

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

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

**Incorporation of Other Legal Requirements**
Any provisions now or hereafter required to be included in this manual by applicable federal and/or state laws and regulations or by CMS shall be binding upon and enforceable against participating providers and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this manual or elsewhere in your agreement.
Conflicts
In the event of a conflict between any specific provision of your agreement and any specific provision of the manual, the specific provisions of your agreement shall control.

Dispute Resolution
Refer to your agreement.

Arizona Medicare Advantage/Medicare Advantage Prescription Drug Plans
The following requirements of the Centers for Medicare & Medicaid Services ("CMS") apply to your provision of services as a participating physician, hospital, ancillary or other health care professional (collectively referred to as 'Health Care Professional') to Cigna HealthCare of Arizona, Inc. ("Cigna") customers covered under Medicare Advantage ("MA") and Medicare Advantage Prescription Drug ("MAPD") plans listed above. Cigna Medicare Advantage customers are hereinafter referenced as "Medicare Participants."

Participating Health Care Professional understands that:

- Medicare Participants may directly access (through self-referral) screening mammography and influenza vaccine services.

- Female Medicare Participants have the option to directly access women's health specialists within the network for women's routine and preventive health care services provided as Medicare-covered basic benefits. Cigna arranges for specialty care outside of the health care professional network when Participating Health Care Professionals are unavailable or inadequate to meet the Medicare Participant's medical needs.

- Cigna cannot prohibit or otherwise restrict Participating Health Care Professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, a Medicare Participant about: 1) the patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options; 2) the risks, benefits, and consequences of treatment or non-treatment; or 3) the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

- Cigna may not require Participating Health Care Professional to indemnify Cigna against any civil liability for damage caused to a Medicare Participant determined to be the result of Cigna's denial of medically necessary care.

- Cigna must offer coverage for the following services provided by non-participating health care professionals and suppliers: (i) ambulance services dispatched through 911 or its local equivalent; (ii) emergency and urgently needed services as provided in 42 CFR § 422.113; (iii) maintenance and post-stabilization care services as provided in 42 CFR § 422.113; (iv) renal dialysis services while the Medicare Participant is temporarily outside Cigna's service area; and (v) services which upon appeal have been determined to be covered services. Cigna meets its regulatory obligations under this provision by making payment in an amount the health care professional would have received under original Medicare.

- Cigna maintains and monitors its network of contracted health care professionals for network accessibility.

- Cigna has written policies and procedures for the selection and evaluation of health care professionals. These policies conform to CMS regulations at 42 CFR § 422.204 and the antidiscrimination provisions at § 422.205. In addition, Cigna will notify physician for the reason for any denial, suspension or...
termination of the Agreement.

- Cigna and Participating Health Care Professional will maintain the confidentiality and accuracy of enrollee records in accordance with 42 CFR § 422.118.

- Cigna will comply with the CMS requirements for the review and approval of marketing materials and election forms and such other requirements as set forth at 42 CFR § 422.80.

- Payment and any applicable incentive arrangements between Cigna, Participating Health Care Professionals and down-stream entities will be specified in the Agreement.

- Cigna will make a good faith effort to provide written notice of a termination of a Participating Health Care Professional at least 30 days before the termination effective date to Medicare Participants who are customers seen on a regular basis by the health care professional. When a contract termination involves a primary care physician (PCP), all Medicare Participants who are customers of the PCP will be notified.

- Cigna will comply with CMS reporting requirements set forth at 42 CFR § 422.504(a)(8) and maintain records as provided for and make such records available as provided for at 42 CFR § 422.504(d)-(e). Cigna will also certify the accuracy of data as provided for at 42 CFR § 422.504 (l).

- Cigna will provide to CMS: Medicare Participant satisfaction; and Medicare Participant health outcomes (in compliance with privacy laws and regulations).

- Cigna will provide participating physicians, in the event Cigna suspends or terminates the Agreement, with the following information: (1) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the number and mix of physicians needed by Cigna and (ii) the physician’s right to appeal the action and the process and timing of the hearing.

- As provided in the Agreement, Cigna and Participating Health Care Professional will provide at least 60 days written notice, or such longer period of time specified in the Agreement, before terminating the Agreement without cause.

- Cigna will not employ or contract with an individual or entity that is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act (or with an entity that employs or contracts with such an excluded individual or entity) for the provision of any of the following: (a) health care; (b) utilization management; (c) medical social work; or (d) administrative services.

- Cigna will not use Federal funds to reimburse health care professionals who have opted out of the Medicare Program. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services.

- Cigna will establish and maintain a grievance procedure, organizational determination procedure and appeal procedure in compliance with CMS requirements. If Cigna delegates its responsibilities, it will remain ultimately responsible for ensuring that the entity or individual satisfies the relevant requirements.

Participating Health Care Professional agrees that it will:

- Not impose cost-sharing (deductibles, coinsurance and/or copayments) for influenza vaccine and pneumococcal vaccine upon Medicare Participants.

- Cigna maintains and monitors its network of contracted health care professionals for network accessibility. Arizona Cigna Medicare Advantage has the following exclusive arrangements by county which Participating Health Care Professional agrees to utilize when making referrals to these specialties or services:

**Maricopa County Exclusive Providers**
<table>
<thead>
<tr>
<th>Provider</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigna Behavioral Health</td>
<td>Behavioral</td>
</tr>
<tr>
<td>American Specialty Health</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>Evicore</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Preferred Home Health DME</td>
<td>DME</td>
</tr>
<tr>
<td>Professional Health Care Network</td>
<td>Home Health</td>
</tr>
<tr>
<td>Coram Infusion</td>
<td>Infusion</td>
</tr>
<tr>
<td>Physical Therapy Provider Network</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>New Century Health (NCH)</td>
<td>Oncology</td>
</tr>
<tr>
<td>Access to Care (A2C)</td>
<td>Transportation</td>
</tr>
</tbody>
</table>

**Pima County Exclusive Providers**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigna Behavioral Health</td>
<td>Behavioral</td>
</tr>
<tr>
<td>American Specialty Health</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>Preferred Home Health DME</td>
<td>DME</td>
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<td>Infusion</td>
</tr>
<tr>
<td>Physical Therapy Provider Network</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>VS SUPERIOR VISION</td>
<td>Optometry/Vision</td>
</tr>
</tbody>
</table>

- Not deny, limit or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA or MAPD plan on the basis of any factor that is related to health status, including but not limited to: 1) medical condition, including mental as well as physical illness; 2) claims experience; 3) receipt of health care; 4) medical history; 5) genetic information; 6) evidence of insurability, including conditions arising out of acts of domestic violence; or 7) disability.
- Provide Covered Services in a manner consistent with professionally recognized standards, evidence based practices and/or nationally recognized clinical protocols.
- Cooperate with Cigna’s written standards for timeliness of access to care and customer services that meet or exceed standards established by CMS. Participating Health Care Professional will cooperate with Cigna’s actions in monitoring to ensure compliance with these standards, as well as Cigna’s corrective actions as necessary.
- Cooperate with Cigna’s written standards for Participating Health Care Professional consideration of Medicare Participant input into the Participating Health Care Professional’s proposed treatment plan.
- Maintain hours of operation that are convenient for and do not discriminate against Medicare Participants. Participating Health Care Professional’s services or coverage for such services are available 24 hours a day, 7 days a week, when medically necessary.
- Provide information regarding treatment options in a culturally competent manner, including the option
of no treatment. Participating Health Care Professional must ensure that Medicare Participants with disabilities have effective communications with individuals within the healthcare system in making decisions regarding treatment options.

- Provide services in a culturally competent manner to Medicare Participants, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.
- Cooperate with Cigna's best effort attempts to assure that an initial assessment of Medicare Participant's health care needs is conducted within 90 days of the effective date of enrollment.
- Maintain a health record for Medicare Participants in accordance with applicable standards for such Participants established by Cigna, taking into account professional standards.
- Document in a prominent part of the Medicare Participant's current medical record whether or not the individual has executed an advance directive; not condition the provision of care or otherwise discriminate against a Medicare Participant based on whether or not the individual has executed an advance directive; educate staff concerning Participating Health Care Professional's policies and procedures on advance directives; and comply with applicable State and Federal law on advance directives.
- Cooperate with Cigna's efforts to consult with Participating Health Care Professional regarding 1) Cigna's Quality Management and Utilization Management programs, and 2) in developing, reviewing and updating periodically practice guidelines and Utilization Management program guidelines that are based on reasonable medical evidence or a consensus of health care professionals in the particular field and consider the needs of Medicare Participants. This provision also applies to any physician group subcontracted to Participating Health Care Professional.
- Assure appropriate and confidential exchange of information among Medicare Participant’s health care professionals.

Further:

- Cigna and Participating Health Care Professional agree to comply with Federal laws and regulations that are applicable to Cigna as provided at 42 CFR § 422.504(h)(1).
- Cigna will disclose to CMS all information necessary to (i) administer and evaluate the Medicare Advantage program; (ii) establish and facilitate a process for current and prospective customers to exercise choice in obtaining Medicare services and to otherwise comply with 42 CFR § 422.64, § 422.504(a)(4) and § 422.504(f)(2). Participating Health Care Professional will provide such data and other information requested by Cigna in furtherance of its obligations hereunder.
- Cigna and Participating Health Care Professional agree to comply with Federal laws and regulations pertaining to Cigna and First Tier, Downstream and Related Entities (FDR). As such, Participating Health Care Professionals or Health Care Professional Groups will develop, participate, and train office staff annually on Medicare compliance requirements, code of conduct, ethics, and Special Needs Plan Model of Care training or request said training from Cigna. Participating Health Care Professional must maintain attendance logs and training materials, which must be made available to Cigna or CMS for audit and inspection.

Please refer to your Medicare Regulatory Addendum for details.
**Overpayment Recovery**

If you receive an overpayment or an otherwise incorrect or inadvertent payment from Cigna or its’s designee, a refund to the payer is required. Send the refund and a copy of the associated explanation of payment to:

Cigna HealthCare of Arizona Medicare Advantage Plan
Attn: Overpayment Recovery Dept.
25500 N. Norterra Drive Bldg. B
Phoenix, AZ 85085

If after notification of overpayment or erroneous payment, the provider has not disputed or refunded the amount within 60 days, Cigna reserves the right to offset against future payments.

**Out of Network Recoupments**

If you refer to an Out of Network provider without approval, Cigna reserves the right to recoup the payment to out of network providers from you. Send the refund and a copy of the associated explanation of payment to:

Cigna Healthcare of Arizona Medicare Advantage Plan
Attn: Overpayment Recovery Dept.
25500 N. Norterra Drive Bldg. B
Phoenix, AZ 85085

If you do not dispute or refund the amount within 60 days, Cigna reserves the right to offset against future payments.
APPENDIX

2020 Plan Offerings

State-Specific Information
In some cases, state law requirements supersede the policies and procedures outlined in this reference guide.

Note: These requirements apply only to the extent required by applicable law and may not apply to participants covered under self-funded plans.

Cigna Participating Service Areas:

The Medicare Advantage service area is Maricopa county, Pima County and select Zip codes; 85117; 85118; 85119; 85120; 85140; 85143; 85178; 85220 within Pinal county.

Arizona
Cigna 2020 Medicare Advantage Counties