For your convenience, some of the more frequently referenced policies and regulatory guidelines have been summarized in this Regulatory Highlights Guide. The guide highlights key regulatory topics that you should be aware of, as well as useful information to help you better serve your Medicare customers. The guide is not intended to be a complete statement of policies and procedures, or all laws and regulations that apply to providers. It is a supporting document to the Provider Manual and you must comply with such provisions set forth in your participating provider agreement.

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Cigna is a health services company committed to helping our nation’s Medicare and Medicaid beneficiaries live healthier, more active lives through personalized, affordable and easy-to-use health care solutions.

› We support healthy aging and meet our customers’ individual health care needs through personal attention, wellness and preventive care.

› We take a team approach to health care by supporting the doctor-patient relationship through clinical and customer engagement, holistic care coordination and detailed analytics.

› We aim for better health results, affordability and customer satisfaction.

For additional information on the regulatory topics outlined in this guide, please review the current Provider Manual at MedicareProviders, Cigna.com > Provider Manual.
HELPING CUSTOMERS

Important information
Cigna customers have certain rights and responsibilities that Medicare Advantage companies and providers must follow (See “Customer Rights and Responsibilities” sub-section of the Provider Manual). Cigna customers have the following rights and responsibilities:

- The right to be treated with dignity and respect.
- The right to the privacy of medical records and personal health information.
- The right to see participating providers, get covered services, and get prescriptions filled within a reasonable period of time.
- The right to participate with providers in making decisions about their health care.
- The right to candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- The right to use advance directives (such as a living will or a power of attorney).
- The right to voice complaints or appeals about the organization or the care it provides.
- The right to get information about their health care coverage and cost.

- The right to get information about Cigna, its services, plan providers, drug coverage, and costs.
- The right to take action if they think they have been treated unfairly or their rights are not being respected.
- The right to make recommendations regarding the organization’s rights and responsibilities policy.
- A responsibility to supply information (to the extent possible) that Cigna and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-on treatment goals, to the degree possible.

(continued on next page)
Customers also have the right to receive more 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 visit Medicare.gov to order this booklet or print it directly from their computer.

PROVIDER ADVICE TO PATIENTS

Cigna will not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient about:

› The customer’s health status, medical care or treatment options (including 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;

› The risks, benefits, and consequences of treatment or non-treatment; and

› The opportunity for the customer to refuse treatment and to express preferences about future treatment decisions.
ELIGIBILITY VERIFICATION

All participating providers are responsible for verifying a customer’s eligibility at each and every visit. Please note that customer data is subject to change. The Centers for Medicare & Medicaid Services (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 customer’s actual benefit coverage for the date of service in question.

You can verify customer eligibility in the following ways.

› Provider Services: 1-800-230-6138, Hours Monday – Friday, 8 a.m. – 5 p.m. CST.
› Call Cigna to verify eligibility when the customer cannot present identification or does not appear on your monthly eligibility list.
› Use HSConnect. The Cigna web portal allows our Medicare providers to verify customer eligibility online by visiting HealthSpring.HSConnectOnline.com/HSConnect.
› Ask to see the customer’s Cigna ID card. Noted on the ID card is the customer’s ID number, plan code, name of Primary Care Physician (PCP), copay, and effective date. Since changes do occur with eligibility, remember that the card alone does not guarantee the customer is eligible.

ID CARD EXAMPLE

### Cigna-HealthSpring Advantage HMO

<table>
<thead>
<tr>
<th>ID</th>
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</thead>
<tbody>
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<td>John Public</td>
</tr>
<tr>
<td>Health Plan</td>
<td>(80840)</td>
</tr>
<tr>
<td>Effective Date</td>
<td>01/01/2020</td>
</tr>
<tr>
<td>PCP</td>
<td>&lt;PCP’s Name&gt;</td>
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</tr>
</tbody>
</table>

| PCP | <$XX> |
| Specialist | <$XX> |
| Emergency | <$XX> |
| Urgent Care | <$XX> |

### Cigna-HealthSpring True Choice PPO

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<thead>
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<th>&lt;Customer ID&gt;</th>
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<tbody>
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<table>
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<tr>
<th>NO PCP Required</th>
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</tr>
</thead>
</table>

| PCP | <$XX> |
| Specialist | <$XX> |
| Emergency | <$XX> |
| Urgent Care | <$XX> |
COVERED SERVICES

All Cigna customers receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, Cigna makes available to each participating PCP a list of their active customers. Along with the customer’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 the Provider Manual.)

Cigna encourages its customers to call their PCP to schedule appointments. However, if a Cigna Medicare 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 Medicare Provider Customer Service at 1-800-230-6138.

DUAL-ELIGIBLE INDIVIDUALS

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

Providers will accept as payment in full Cigna’s payment and will not seek additional payment from the state or dual-eligible customers. Additional information concerning Medicaid provider participation is available at Cigna.com/Medicare/.
ADVANCE DIRECTIVES

The Federal Patient Self-Determination Act grants patients 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 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 customer’s medical record whether the customer has executed an advanced directive.

If the PCP and/or treating provider cannot, as a matter of conscience, fulfill the customer’s written advance directive, he/she must inform the customer and Cigna. Cigna Medicare 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 patient medical record reviews to confirm that required documentation exists.
CUSTOMER HOLD HARMLESS

Participating providers are prohibited from balance billing Cigna customers including, but not limited to, situations involving nonpayment by their Cigna Medicare plan, insolvency of Cigna, or Cigna’s breach of its agreement. The 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 copays, coinsurances or deductibles for covered services, in accordance with the terms of the applicable customer’s benefit plan.

CUSTOMER GRIEVANCES

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 provider.

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

› Dissatisfaction with the office experience, such as excessive wait times (office wait time, check-in or check-out times exceeds 30 minutes), physician behavior or demeanor, or inadequacy of facilities.
› Involuntary disenrollment situations.
› Poor quality of care or services received.
› Receiving incorrect charges or copays, or balance billing (Reference Dual-eligibles Section). This includes situations when a customer is not properly informed of copays or deductibles before receiving treatment. Refer customers to the Customer Service number listed on their ID card for information on covered services.
› 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 (reference Access and Availability Requirements Section).
› Physician discharge of customer from practice without proper advanced notice.
› Inability to obtain a timely referral from provider.
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 Cigna 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.

**SPECIAL NEEDS PLAN MODEL OF CARE**

Special Needs Plans (SNPs) are designed for specific groups of customers with special health care needs. The three SNP groups are:

- **D-SNP** – This plan is for dual-eligible beneficiaries who are eligible for both Medicaid and Medicare.
- **C-SNP** – Individuals with chronic conditions can enroll in this plan. Cigna’s Medicare plans offer a C-SNP for individuals with diabetes.
- **I-SNP** – This plan is for individuals who are residents of a long-term care facility.

Medicare plans are required to have a Model of Care (MOC) for each SNP type. The MOC is an evidenced based care management model, which integrates care coordination and benefits for customers enrolled in a Cigna Medicare plan SNP. SNP customers receive additional services and coordination of care to improve their overall health. The MOC facilitates the early assessment and identification of health risks through a Health Risk Assessment, the development of an individual care plan, which is monitored by care management teams to identify health status changes. Additional coordination is available by an Interdisciplinary Care Team (ICT). To discuss and/or request a copy of an SNP customer’s care plan, refer an SNP customer for an ICT meeting, or participate in an ICT meeting, please contact our Case Management department. Case Management department phone numbers vary by market. Visit the “Special Needs Plan Model of Care” section of the Provider Manual for contact information.

*(For more information see the 2020 Model of Care Training for Providers at MedicareProviders.Cigna.com > Provider Manual > Special Needs Plans Model of Care (SNP MOC).*
PHYSICIAN PARTICIPATION

Rules and standards
Cigna maintains standards for physician participation as set forth in the provider contract and the Provider Manual. Cigna may initiate a termination/nonrenewal of a provider contract for failure to meet any of the participation standards. For detailed information on the rules of participation, visit the following Provider Manual sections: Credentialing and Recredentialing Program and Provider Information.

MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The terms and conditions in the Cigna’s Medicare Provider Manual and in this regulatory booklet 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 are subject to amendment in accordance with federal statutory and regulatory changes to the Medicare Advantage program. Such amendment shall not require the consent of provider or Cigna and will be effective immediately on the effective date thereof. In the “Medicare Advantage Program Requirements” section of the online Provider Manual, you will find detailed information on:

› Books and records; governmental audits and inspections
› Privacy and confidentiality safeguards
› Customer hold harmless
› Delegation of activities of responsibilities
› Prompt payment
› Subcontracting
› Compliance with laws
› Program integrity
› Continuation of benefits
› Incorporation of other legal requirements
› Conflicts
TERMINATION PROCEDURES AND APPEAL RIGHTS

Cigna provides terminating and non-renewing physicians written notification of the intent to terminate their agreement. The written notice also includes the physician’s right to appeal the termination decision and request an appeal hearing, as well as the process and timing for an appeal. Providers are also required to notify Cigna in writing of their intent to terminate their agreement. Reference your provider agreement for notification requirements.

CREDENTIALING REQUIREMENTS

All practitioner and organizational applicants to Cigna must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. Once an application has been submitted, the provider is subject to a rigorous verification process that includes primary and secondary source verifications of all applicable information for the contracted specialty(ies). 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 or be included in a provider directory without undergoing the credentialing verification and peer review process. All providers who have been initially approved for participation are required to recredential at least once every three years in order to maintain participation status.
NO ENGAGEMENT ACTIVITIES THAT CONFUSE/MISLEAD

Cigna will not distribute printed information comparing benefits of different health plans with providers or provider groups unless the materials have received prior approval from CMS and Compliance, in accordance with current Medicare marketing guidance. Providers can provide acceptable assistance to patients that are inquiring about Medicare plans. Cigna does not financially reward providers for enrolling customers into the plan and does not make payments to providers, directly or indirectly, as an inducement to reduce or limit medically necessary services furnished to any particular customer. Providers must remain neutral and may not:

› Urge or steer toward 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 disenrolling from the health plan to encourage re-enrollment in another 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.

Provider and/or provider groups that accept marketing materials from Cigna must also accept materials from all other Medicare Advantage Organizations (MAOs) with which they participate. Providers must only offer customers assistance that results in a plan selection that is in the best interest of the customer.
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 demographic information 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 Provider Customer Service.

Provider Customer Service: 1-800-230-6138, Monday – Friday: 8 a.m. – 5 p.m. CST

- Practice address.
- Panel status.
- Billing address.
- Fax or telephone number.
- Hospital affiliations.
- Practice name.
- Providers joining or leaving the practice (including retirement or death).
- Providers taking a leave of absence.
- Practice mergers, changes of ownership and/or acquisitions.
- Adding or closing a practice location.
- Tax Identification Number (please include W-9 form).

- National Provider Identifier (NPI) number changes and additions.
- Changes in practice office hours, practice limitations or gender limitations.

Cigna will also, on a quarterly basis, contact you to verify the demographic information we have on file is accurate. By providing this information and responding in a timely manner, you will ensure that your information is listed correctly in the Provider Directory.

NOTE: Failure to provide up-to-date and correct demographic information regarding your practice and the physicians that participate may result in the denial of claims for you and your physicians.

PROVIDER ANTI-DISCRIMINATION

No health care professional shall be discriminated against by Cigna in reimbursement, participation or based on the population of patients served by the health care professional. Any health care provider wishing to contract with Cigna may submit a letter of interest or Provider Application Request on the Cigna Medicare Provider website. Cigna reviews all letters of interest received and either accepts or denies the provider’s request. Participation decisions shall be based on a needs assessment performed related to the specialty of the provider and other related factors. Should a provider be declined participation by Cigna, a written notice is provided to the provider outlining the reasoning behind the declination.
PROVIDER INFORMATION

Helpful information about your role
MEDICAL RECORD DOCUMENTATION STANDARDS

Cigna has standards for customer medical records. These standards are outlined in the Provider Manual, Customer Medical Records Section.

**NOTE:** Unless otherwise specifically stated in your provider services agreement, medical records shall be provided at no cost to Cigna and Cigna Medicare customers.

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 10 years from the later to occur 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. For additional information on medical record standards, visit the Medicare Advantage Program Requirements of the Provider Manual.
SERVICES PROVIDED WITH CULTURAL COMPETENCE AND LANGUAGE SERVICES

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 Medicare Provider Customer Service at 1-800-230-6138 to assist with translator services if these services are not available in their office location. TTY dial 711.

ACCESSIBILITY AND AVAILABILITY REQUIREMENTS

Cigna ensures that reasonable standards for network accessibility, appointment availability and after-hour call coverage are maintained by contracted providers. Performance standards are available on-demand on the Cigna Medicare provider website. In general, providers must ensure that:

- They arrange for customer care 24 hours a day, seven days a week,
- They can care for customers during regular business hours as well as for urgent medical events, which may occur after normal working hours.
- Customers are able to contact providers after normal working hours (9 a.m. – 5 p.m., Monday – Friday).

Cigna measures provider compliance with access and availability standards through the appointment availability and after-hours care survey. The survey is conducted on a yearly basis for randomly selected providers.
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 the declaration effective date, Cigna:

› Waives authorizations and referrals in full and does not require them for customers in the affected counties for Medicare-covered benefits. However, authorizations and referrals are still subject to plan limitations.

› Temporarily reduces plan-approved out-of-network cost-sharing to in-network cost-sharing amounts.

› 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:

› A physician practicing in an affected county, but treating a Medicare Advantage Prescription Drug (MAPA) patient 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 patient who resides in an affected county, will not require a referral or authorization.

Cigna Medicare plans maintain 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.
PROVIDER DIRECTORY UPDATE REQUIREMENTS

Per Chapter 4 of the Medicare Managed Care Manual, MAOs are expected to update directory information anytime they become aware of changes. All updates to the online and print provider directories are expected to be completed within 30 days of receiving information.

MAOs should contact their network/contracted providers on a quarterly basis to update the following information in provider directories.

› Ability to accept new patients;
› Street address;
› Phone number; and
› Any other changes that affect availability to patients.

MAOs should contact providers using a method that is likely to achieve the highest response rate. It is not sufficient to determine that a group practice is accepting new patients.

All providers listed in hard copy or online directories must have current contracts to participate in the Medicare Advantage (MA) plan network. Directories provided during the Annual Enrollment Period (AEP) for the upcoming plan year are expected to fairly represent the network for the upcoming plan year.

Per these requirements, Cigna Medicare plans reach out to all providers on a quarterly basis to verify the information contained in the directory through the Council for Affordable Quality Healthcare (CAQH) and direct mailing.

› If you participate with (CAQH), Cigna Medicare plans will receive any updates made within your 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 ProView, you will need to take the following steps.

1. Log in to your CAQH ProView profile at https://proview.caqh.org.
2. New users can go to https://proview.caqh.org to create a secure account. Review CAQH’s step-by-step videos and user guides before you start.
3. Navigate to the “Practice Locations” section to update your profile.

   Review and update all the required fields to make sure patients can find you.

   - Ensure you indicate current practice name, suite number, whether you are accepting new patients, etc., so the most accurate and up-to-date information is included in directories.

   - Avoid duplicate addresses. If one location (e.g., a medical complex) houses multiple practices, be sure to include suite numbers to distinguish the addresses.

   - Describe your practice affiliation for each location so health plans can determine whether it belongs in their directories.

   - 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.

- Share the phone number patients can call to make an appointment in the “Office Phone Number” field.

4. Review and attest to your CAQH ProView profile. Address any errors by navigating to the corresponding section and making updates. Click “Attest” once you confirm that the status bar at the top of your profile, “Profile Data,” shows the word “Complete” in green.

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.

If you do not participate with CAQH or are a facility or ancillary provider, Cigna will send a quarterly notice to each service location for a provider. Providers receiving this notification are expected to visit Cigna’s Medicare Provider Data Validation website at https://chsproviderdatavalidation.com to validate the information currently displayed within the provider directory through the following steps.

1. Log in to the site using the NPI number and last name or business name contained in the notification.
2. Review and submit changes as needed.
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.

Phone outreach will be completed if a provider does not attest within CAQH and/or does not attest within the Cigna Medicare Provider Data Validation website on a quarterly basis. Please submit any changes in a timely manner so we can ensure your patients are able to find you.
QUALITY IMPROVEMENT PROGRAM

Overview
QUALITY IMPROVEMENT PROGRAM OVERVIEW

The Quality Improvement 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 program describes the processes and resources to continuously monitor, evaluate and improve the clinical care and services provided to customers 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.

QUALITY IMPROVEMENT PROGRAM OBJECTIVES

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 goal of the organization is to maintain an effective quality committee structure that:

- Fosters communication across the enterprise
- Collaboratively works toward achievement of established goals
- Monitors progress of improvement efforts to established goals
- Provides the necessary oversight and leadership reporting

- Ensures patient care and service is provided according to established goals and metrics
- Ensures identification and analysis of opportunities for improvement with implementation of actions and follow-up as needed
- Promotes consistency in quality program activities
- Ensures the Quality Improvement 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
- Ensures timely access to and availability of safe and appropriate physical and behavioral health services for the population served
- Ensures services are provided by qualified individuals and organizations, including those with the qualifications and experience appropriate to service customers with special needs
- Promotes the use of evidence based practices and care guidelines
- Improves the ability of all Cigna team members to apply quality methodology through a program of education, training, and mentoring
- Establishes a rigorous delegation oversight process
- Ensures adequate infrastructure and resources to support the Quality Improvement Program
- Ensures provider involvement in maintaining and improving the health of their customers, through a comprehensive provider partnership
MEDICAL MANAGEMENT PROGRAM

Cigna’s Medical Management Program evaluates and strives to positively influence the quality of care, service, affordability, and medical outcomes of all who access the Utilization Management, Complex Case Management, and Pharmacy and Behavioral Health Benefit Management programs, as well as various other specialty programs available by contract. The goal of the Medical Management Program is to promote a customer-centric approach to program delivery, facilitate the provision of quality, cost-effective medical care, promote individual education, and better the achievement of medical outcomes, all within the scope of program delivery.

Cigna views an effective, integrated managed care program as one that provides contracting, utilization management and data analytics services for all significant health care benefits, including medical/surgical care, integrated behavioral health care, long-term complex case management, pharmacy management, and chronic care management. Our Medical Management Program, including utilization management activities, meets these expectations through a comprehensive collection of activities, programs and initiatives aimed at ensuring the delivery of safe, medically appropriate, high-quality, and cost-effective evidence based medical care with the aim of improving medical outcomes and meeting our customer’s individual health goals. The specialized programs and activities in the Medical Management Program include:

- Utilization Management – Benefit coverage and medical necessity review of medical, behavioral health and pharmacy services;
- Chronic Care Management, which includes Complex Case Management and Disease Management;
- The Alegis Program, which provides for physicians and nurse practitioners to see patients in the home when needed; and
- Medication Therapy Management.
HEALTH SERVICES

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 customers. For information on prior authorizations, utilization management criteria, referral management, or other utilization questions, call toll-free 1-800-230-6138, 8 a.m. – 5 p.m. CST, Monday – Friday. You may also visit the provider manual Health Services section at MedicareProviders.Cigna.com>Provider Manual > Medical Health Services.

CHRONIC CARE MANAGEMENT (DISEASE MANAGEMENT)

Cigna’s Chronic Care Management Program is a comprehensive multidisciplinary approach to the management of customers across the spectrum of care with chronic, complex and disease-specific care needs. The Chronic Care Management Program is supported by a multidisciplinary team of health care professionals with experience in the clinical management of customers with multiple chronic conditions and long-term complex medical and social support needs. Key components of the Chronic Care Management Program are to provide early identification and intervention for customers with medical, pharmaceutical or behavioral health needs who would benefit from:

- Improved self-management skills
- Referrals to adjunct programs
- Complex Case Management*
- Disease Management*
- Assistance with coordinating plan benefits and/or community resources
- Reduction in the frequency and/or intensity of a chronic illness exacerbation
- Closure of gaps in preventive care measures

The program’s Disease Management goal is to actively work to improve the health status of customers with chronic conditions which include, but are not limited to, diabetes, congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease (COPD).

HOW CUSTOMERS ARE REFERRED FOR CHRONIC CARE MANAGEMENT

- A PCP, specialist or other health care professional can refer customers. Customers will get a phone call or letter to review their needs and get started.
- Cigna may call customers who may benefit from the program.
- Customers can refer themselves, or a caregiver can call us on their behalf.

Both programs are available to Cigna Medicare plan customers who qualify.

Participation is voluntary and customers can join or leave both programs at any time.

For information, call:
1-877-562-4395, Option 1 (TTY 711)
8 a.m. – 5 p.m., Monday – Friday for Pennsylvania, Maryland, Delaware and Washington, DC
1-877-376-5193 (TTY 711)
8 a.m. – 5 p.m., Monday – Friday for Illinois and Indiana

* Not available in all markets and diseases addressed may vary between markets.
CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES

In consultation with its participating providers, Cigna adopts evidence based Clinical Practice Guidelines (CPGs) that are based on valid and reliable clinical evidence and are appropriate to the needs of customers. CPGs are reviewed annually as national guidelines change, assuring guidelines reflect changes and/or advances in technology and scientific findings.

All contractually required covered services coordinated by Cigna are in accordance with departmental policies and prevailing professional community standards. Cigna provides ongoing education to providers on required clinical guideline application when clinically appropriate, and ongoing monitoring and use of the guidelines. Monitoring includes, but is not limited to, analysis and assessment of HEDIS, CAHPS, annual review of provider documentation and preventive quality indicators, as well as utilization patterns for inpatient admissions, readmissions and emergency department services. Detailed information on the following guidelines can be located in the online Provider Manual.

› Asthma
› Atrial fibrillation
› Back Pain
› Case Management
› Cholesterol
› Chronic kidney disease
› COPD
› Community-acquired pneumonia
› Cardiovascular disease
› Smoking cessation
› Tuberculosis
› Diabetes
› Falls
› Chronic Heart Failure (CHF)
› Hypertension
› Obesity
› Osteoporosis
› Peripheral arterial disease
› Myocardial infarction
› Preventive Care
› Family planning and reproductive health
› Pharmacy services
› Depression
› Stress
**PRIOR AUTHORIZATION**

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for medical necessity review before an item or service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization allows for medical necessity review prior to service delivery to help prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care. The prior authorization process assures that all relevant clinical documentation requirements are met before the item or service is furnished to the beneficiary and before the claim is submitted for payment.

Cigna has compiled a master list of services that require prior authorization. The list can be located in our Provider Manual and on our website. If you are uncertain about the prior authorization requirement for a specific procedure, you may also reach out to our Provider Customer Service Department from 7 a.m. – 6 p.m. CST at 1-800-230-6138.

Log in to HSConnect or contact Customer Service to verify benefits, coverage and customer eligibility. Authorization requests may be submitted by mail, phone, fax or Cigna’s portal, HSConnect, 24 hours per day, seven days per week. After confirming a customer’s eligibility and the availability of benefits, providers should submit all supporting documentation with the organization determination request via our provider portal, fax or phone.

<table>
<thead>
<tr>
<th>State</th>
<th>Fax Number/Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>FAX: 1-205-444-4263 Call: 1-800-962-3016 or 1-205-423-1222</td>
</tr>
<tr>
<td>Southern Mississippi and Northwest Florida</td>
<td>FAX: 1-800-872-8685 Call: 1-800-962-3016 or 1-205-423-1222</td>
</tr>
<tr>
<td>TN Home Health – Additional Visits</td>
<td>FAX: 1-615-263-5478 Call: 1-615-401-4667</td>
</tr>
<tr>
<td>Transfer of SNF/Rehab/LTAC</td>
<td>FAX: 1-855-662-7973 Call: 1-888-0200-1037</td>
</tr>
<tr>
<td>Georgia (All counties, excluding Catoosa, Dade, and Walker)</td>
<td>FAX: 1-855-388-1452 Call: 1-866-949-7103</td>
</tr>
<tr>
<td>Tennessee, Northern Georgia and Eastern Arkansas</td>
<td>FAX: 1-866-287-5834 or 1-615-291-7545 (TN only) Call: 1-800-453-4464</td>
</tr>
<tr>
<td>Illinois</td>
<td>FAX: 1-866-287-5834 or 1-855-544-0625 (IL only) Call: 1-800-230-7298</td>
</tr>
<tr>
<td>Kansas City, Colorado</td>
<td>FAX: 1-866-464-0707 or 1-888-545-0024 (Inpatient Admission FAX Line) Call: 1-888-454-0013</td>
</tr>
<tr>
<td>South Carolina</td>
<td>FAX: 1-855-420-4717 Call: 1-866-949-7101</td>
</tr>
<tr>
<td>Texas</td>
<td>FAX: 1-888-856-3969 Call: 1-800-511-6932</td>
</tr>
<tr>
<td>Behavioral Health (All Markets)</td>
<td>FAX: 1-866-949-4846 Call: 1-866-780-8546</td>
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(Visit the Medical Health Services section of the Provider Manual.)
Prior Authorization

The Prior Authorization Department, under the direction of licensed nurses, clinical pharmacists and medical directors, documents and evaluates requests for authorization. Be sure to include the following information to ensure your request can be processed.

› Customer name and ID number
› Location of service (e.g., hospital or surgi-center setting)
› Ordering physician/provider name
› Servicing/attending physician name, along with Tax Identification Number (TIN) or Provider Identification Number (PIN)
› Date of service (start of care/end of care)
› Diagnosis
› Service/procedure/surgery description and CPT or HCPCS code
› Clinical information supporting the need for the service to be rendered

Organization Determination Requests and Time Frames

An organization determination is any decision (approval or denial) made by a Medicare health plan regarding payment for or authorization of requested services in whole or in part, including the type or level of service. An enrollee, an enrollee’s representative or a servicing provider may request an organization determination by filing a prior authorization request with their Cigna Medicare plan.

Expedited Organization Determination

An expedited request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the customer’s life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined as expeditiously as the health condition requires, but no later than 72 hours after receipt of the request.

Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received.

Standard or Routine Organization Determination

A standard or routine request will be determined as expeditiously as the health condition requires, but no later than 14 calendar days after receipt of the request.

Approval:

Once the Prior Authorization Department receives the request for authorization, the request is reviewed using nationally recognized industry standards or local coverage determination criteria. If the request for authorization is approved, Cigna will assign an authorization number and enter the information in our medical management system. This authorization number can be used to reference the admission, service or procedure. Approval notification is provided to the customer and provider.
**Adverse Determination:**

Only a Cigna Medical Director may render an adverse determination (denial) based on medical necessity, but he/she may also make a decision based on administrative guidelines. If the Medical Director makes a determination to deny or limit procedure or service, Cigna will notify the facility/provider’s office and the customer of the denial of service. The notice will include documentation of the original request that was denied, the reason the request was denied, and the process for appeal.

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

The criteria used in rendering the medical necessity determination is available to the provider and member upon request.

**Retrospective Prior Authorization Requests**

Retrospective prior authorization requests, or requests submitted after care/services have been provided, will not be reviewed for medical necessity unless:

- Medically necessary services were provided to Cigna customers after hours, holidays or weekends and the retrospective request with clinical information is received within one business day of the start of care

- A claim was billed to an incorrect carrier and a new request, with the denied Remittance Advice (RA), is received by Cigna within two business days of RA receipt

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.
PHARMACEUTICAL MANAGEMENT

Detailed information regarding Part D drugs and their utilization management (prior authorizations, step therapy, and quantity limits) may be found in the Pharmacy Prescription Benefit section of the Provider Manual. The most recent plan formularies may be accessed at Cigna.com/medicare/resources/drug-list-formulary.

Requests for coverage determination (CD) of pharmacy benefits may be received by the provider call center either by calling 1-877-813-5595 (7 a.m. – 8 p.m. CST, Monday – Friday, or by faxing 1-866-845-7267). To ensure timely review of CDs and that the prescriber is aware of CD requirements for the most commonly requested drugs, forms are available online at Cigna.com/healthspringdrugforms or by requesting a fax when calling 1-877-813-5595.

If a provider disagrees with the results of a CD, a Part D appeal may be filed within 60 calendar days after the date of the CD decision. Part D appeals may be received orally or in writing from the customer’s prescribing physicians by calling 1-866-845-6962, or faxing 1-866-593-4482.

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 prescription drug monitoring program (PDMP). You may find your state’s PDMP at PDMPassist.org/content/state-pdmp-websites.

PHARMACEUTICAL QUALITY PROGRAMS

(Visit the Pharmacy Quality Programs section of the Provider Manual.)

Our pharmacy quality programs prospectively and retrospectively engage members and providers in an effort to assure pharmaceuticals are used both safely and judiciously. These initiatives include:

› Narcotic Case Management (NCM): Pharmacy claims for controlled substances are reviewed monthly for potential overutilization or inappropriate utilization. If our clinical staff determine further investigation is warranted, prescribers will be individually contacted to discuss options for collaborative management.

› Medication Therapy Management (MTM): Eligible members will be contacted for a comprehensive medication review on an annual basis by our clinical staff. Any potential concerns are forwarded to the prescribing provider along with the member’s four-month medication history.

› Drug Utilization Review: Concurrent drug utilization review occurs at the pharmacy point-of-sale and includes review of a medication’s dosage, interactions, and any duplicate therapies. Retrospective Drug Utilization Review evaluates previous claims data to determine when follow-up with a member or prescriber may be necessary.

(Visit the Pharmacy Quality Programs section of the Provider Manual.)
CLAIM PAYMENT

Processing, payment, appeal guidelines
While Cigna prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact Cigna Provider Customer Service for assistance at 1-800-230-6138.

TERMS AND CONDITIONS OF PAYMENT

Claims Adjudication, Submission, and Reconsideration guidelines

Timely filing - As a Cigna Medicare plan participating provider, you have agreed to submit all claims within the time frames outlined in your provider agreement. Claim format standards: Standard CMS-required data elements can be found in the CMS claims processing manual located at CMS.gov/manuals/downloads/clm104c12.pdf and 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, the claim accuracy rests solely with the provider.

PAYMENT AND APPEAL PROCESS

An appeal is a request for Cigna to review a previously made decision related to medical necessity, clinical guidelines, or prior authorization and referral requirements. 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 or within the time frame specified in your contract. 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 provider agreement.

MANUAL/ELECTRONIC BILLING REQUIREMENTS AND ELECTRONIC FUNDS TRANSFER PROCESS

Through our partnership with Change Healthcare, we are pleased to continue offering simpler, more efficient ePayment solutions such as electronic funds transfer (EFT) and electronic remittance advice (ERA) to help you:

- Maximize revenue and profit
- Reduce costs and errors
- Increase payment efficiency

Additional information on EFT and ERA can be located in the ERA/EFT Enrollment Process section of the Provider Manual.

(For more information on claims processing, payment, appeal guidelines and conditions of payment, please refer to the Claims section of the Provider Manual.)
CIGNA 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. 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 (FWA)

To report suspected or detected Medicare program noncompliance 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
ATTN: Cigna Medicare Operations

By phone:
1-800-667-7145

For more information on FWA, please refer to the FWA section of the Provider Manual. 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.
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 online training:

- At CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
- With select fraud and abuse educational products
- With the 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.
NOTES: _____________________________________________________________

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Together, all the way.