CIGNA REFERENCE GUIDE

For participating physicians, hospitals, ancillaries and other health care providers

Together, all the way.™

803774q 7/20
PCOMM-2020-479

Cigna®

Table of Contents

Introduction

Inside the guide

Welcome to Cigna! For starters, we'd like you to know that we're committed to giving all of our customers access to quality services and benefits. That means working with you across all the aspects of today's health care world. To help us stay on the same page, we have created this Reference Guide for you. It highlights the programs and policies intended to keep our relationship smooth and productive – for the sake of the people we serve together.

The Reference Guide contains Administrative Guidelines and Program Requirements for the programs, policies, rules, and procedures pertaining to Cigna's insured or administered benefit plans. We will give you advance notice of material changes to our Administrative Guidelines and Program Requirements.

Your Cigna Participating Provider Agreement and this Reference Guide describe many of the terms under which you agree to provide services to Cigna Plan Participants. Those terms include the reimbursement rates applicable to Covered Services provided to Participants. However, the actual benefits payable by a Payer for Covered Services provided to a Participant in all cases is determined by the terms of the Payer's Benefit Plan. The Reference Guide applies to all Cigna business including plans for Participants with "G" ID cards.

Our commitment and mission

We are committed to working with hospitals, ancillary facilities, physicians and other providers 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 sense of security. We measure our performance through annual provider 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

Not all Administrative Guidelines and Program Requirements are outlined in this guide. Other Administrative Guidelines and Program Requirements or updates may be posted on the Cigna for Health Care Professionals website at CignaforHCP.com or communicated through notifications we deliver by mail, email, phone, fax, or in person.

State-Specific Information

In some cases, state law requirements supersede the policies and procedures outlined in this Reference Guide. Please review the state-specific information for any requirements specific to your state.

Alabama (AL) *	Alaska (AK) *	Arizona (AZ)
Arkansas (AR) *	California (CA)	Colorado (CO)
Connecticut (CT)	Delaware (DE)	Florida (FL)
Georgia (GA) *	Hawaii (HI) *	Idaho (ID) *
Illinois (IL)	Indiana (IN)	Iowa (IA) *
Kansas (KS)	Kentucky (KY) *	Louisiana (LA)
Maine (ME)	Maryland (MD)	Massachusetts (MA)
Michigan (MI)	Minnesota (MN) *	Mississippi (MS) *
Missouri (MO) St. Louis	Montana (MT)*	Nebraska (NE) *
Nevada (NV)	New Hampshire (NH)	New Jersey (NJ)
New Mexico (NM)	New York (NY)	North Carolina (NC)
North Dakota (ND) *	Ohio (OH)	Oklahoma (OK)
Oregon (OR)	Pennsylvania (PA – Metro Philadelphia) Pennsylvania (PA - Other)	Rhode Island (RI)
South Carolina (SC)	South Dakota (SD) *	Tennessee (TN)
Texas (TX)	Utah (UT)	Vermont (VT)
Virginia (VA)	Virgin Islands (VI)	Washington DC Washington (WA) Washington (Southwest, WA)
West Virginia (Eastern, WV) West Virginia (Western, WV)	Wisconsin (WI)	Wyoming (WY) *

Note: These requirements apply only to the extent required by applicable law and may not apply to Participants covered under self-funded plans. States listed with an asterisk (*) will use this guide as a reference.

Important Contact Information

Find the contact you need for information about your patients with Cigna coverage.* Please note that call, claim, and service channels may differ based on the Cigna participant's identification (ID) card.

If you want to:	Use the following:
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 • Type/degree • Specialty • Product and network tier • National Provider Identifier (NPI) number • Medical group or hospital affiliation • Office email address • Address • Office phone number • Whether you are accepting new patients	Log in to the Cigna for HealthCare Professionals website to use our updated online change form. If you haven't registered yet, please go to the registration page to begin the process. Or Email: Intake_PDM@Cigna.com Fax: 877.358.4301 Mail: Cigna Provider Data Management Two College Park Dr. Hooksett, NH 03106
Perform online transactions:** • Verify patient eligibility • Inquire about patient coverage and covered services • Predict the total cost of service and patient liability for specific medical procedures • Request precertification for services • Inquire about precertification for services • View claim-coding policies and payment guidelines • Review medical or pharmacy coverage positions • View the prescription drug list • View sample ID cards • Obtain a Reference Guide • Request a copy of your contract • Request fee schedule information	Cigna for Health Care Professionals website: CignaforHCP.com
Perform transactions using a multipayer website or vendor via electronic data interchange (EDI):** • Verify patient eligibility and coverage • Inquire about patient coverage and covered services • Check the status of a claim • Request precertification for services • Submit claims electronically • Receive electronic remittance advice • View list of EDI vendors	Refer to Cigna.com/EDIvendors for a list of directly connected Cigna vendors.

If you want to:	Use the following:
Enroll to receive electronic funds transfer (EFT) or direct deposit	Enroll in electronic funds transfer (EFT) and manage EFT accounts with multiple payers, including Cigna, using the Council for Affordable Quality Health Care (CAQH) website: https://solutions.CAQH.org Enroll in EFT directly with Cigna by logging in to CignaforHCP.com > Working with Cigna > Electronic Funds Transfer > Enroll in Electronic Funds Transfer (EFT) Options
Perform telephone transactions:** • Learn about electronic services • Verify patient eligibility and coverage • Check the status of a claim • Request precertification for services • Request an exception to the prescription drug list	Phone: 800.88Cigna (882.4462) For patients with "G" ID cards: Phone: 866.494.2111 Customer Service numbers are also included on the patient's ID card.
Submit a paper claim	Refer to patient's ID card
Submit or inquire about an appeal or dispute	Phone: 800.88Cigna (882.4462) Fax: 877.815.4827 Mail: Cigna National Appeals PO Box 188011 Chattanooga, TN 37422 For patients with "G" ID cards: Fax: 877.804.1679 Mail: Cigna National Appeals PO Box 188062 Chattanooga, TN 37422-8062
Submit or inquire about provider credentialing	Phone: 800.88Cigna (882.4462)
Obtain information about organ and tissue transplant network	Cigna *Life*SOURCE Transplant Network® Phone: 800.668.9682 Website: CignaLifeSOURCE.com
Contact a dental network	Phone: 800.Cigna24 (244.6224) Website: CignaforHCP.com For patients with "G" ID cards: Phone: 866.494.2111
Obtain other telephone numbers and addresses	Refer to the participant's ID card

Other important contacts:	
Cigna Behavioral Health	Phone: 800.926.2273 Website: CignaforHCP.com
Home delivery pharmacy	Cigna Home Delivery Pharmacy: 800.285.4812 Express Scripts Pharmacy, a Cigna company: 800.211.1456
Accredo, a Cigna specialty pharmacy	Accredo Physician Service Center: 844.516.3319 Website: Accredo.com > Prescribers
Medical management (including precertification)	Phone: 800.88Cigna (882.4462) Website: CignaforHCP.com For patients with "G" ID cards: Phone: 866.494.2111 Customer service numbers are also included on the patient's ID card.
eviCore healthcare (diagnostic cardiology, gastroenterology, high-tech radiology, integrated oncology, musculoskeletal, and radiation therapy services)	**Diagnostic cardiology, high-tech radiology, and musculoskeletal** Phone: 888.693.3211 Website: eviCore.com **Gastroenterology, radiation therapy and integrated oncology** Phone: 866.668.9250 Website: eviCore.com **Exceptions** For CareLink customers in MA and RI and Cigna customers in Hawaii and Puerto Rico, use the following contact information: Phone: 800.88Cigna (882.4462) Website: CignaforHCP.com
Pharmacy prior authorizations	Electronic medical record or electronic health record: CoverMyMeds® or Surescripts® Phone: 800.244.6224 Online: CoverMyMeds.com/epa/Cigna
Specialty pharmacy condition counseling	Accredo Therapeutic Resource Centers: 844.516.3319 Cigna specialty condition counseling: 800.633.6521

Click here for a printer-friendly version of this "Important Contact Information."

** Excluding customers with third party administrator plans.*
***Not all transactions are available for all Cigna plans.*

Demographic Information and Directories

We use your demographic information to:

- Publish online provider directories
- Send communications to providers
- Process claims
- Assign a Primary Care Provider for those participants with benefit plans that require one to be selected and the participant has not done so
- Comply with state laws requiring accurate directory listings
- Determine network adequacy

Notify us in writing 90 days before any changes to your practice demographic information. Examples of such changes include changes in address/office location, billing address, telephone number, tax identification number, specialties, and new individual NPI or organization NPI. It is also important for you to update your status if you are no longer accepting new patients as this element is included in provider directories and relied upon by consumers.

It is essential that you consistently identify yourself in written communications and claim submissions. Using abbreviations, variations of names, physician licensure or tax identification numbers not listed in a provider agreement and/or not provided to Cigna in advance of the change may result in delayed changes to the provider directories and incorrect claim payments. The latest provider directory is available at Cigna.com.

Submit demographic changes to Cigna electronically by logging in to CignaforHCP.com > Working With Cigna > Update Directory Information.

You may also submit demographic changes using the following fax and email addresses:

- For Practitioner & Group Changes:
  - Fax: 877.358.4301
  - Email: Intake_PDM@cigna.com
- For Hospital & Ancillary Changes:
  - Fax: 646.459.2180

Benefit Plan Designs and Features

Cigna Participants Only

The following chart provides a summary of Cigna's benefit plan design options and the benefit plan types in which they are included as determined by Cigna. Please note that this does not represent a complete listing of Cigna's benefit plan design options.

Benefit plan name on the ID card	HMO Network	POS	Cigna SureFit	Connect Network	Focus Network	HMO Open Access Network Open Access	POS Open Access	LocalPlus	LocalPlusIN	Open Access Plus	Open Access Plus In-network	PPO	EPO	Indemnity
Primary care provider (PCP) selection criteria	PCP selection required				PCP selection optional							No PCP designation available		
Specialty care referral requirements	Specialty care referral required (excluding OB/GYN or other state-mandated direct access)				Referrals not required									NA
In-network tiered benefits available	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes	Yes	NA
Out-of-network benefits	No	Yes	No	No	No	Yes	No	Yes	No	Yes	No	Yes	No	NA
HSA and HRA integration available	No	No	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Inpatient pre-certification	Inpatient pre-certification is always required except in an emergency													
Outpatient pre-authorization	Refer to covered individual's ID card for outpatient pre-authorization requirements													

Plan	Highlights
Cigna SureFit	Cigna SureFit benefit plans build networks around local physician and hospital groups providing customers access to personal, patient-centered care. Highlights: • PCP selection is required, where permitted. • Referrals are required. • No out-of-network coverage unless an emergency or urgent care. • You are responsible for obtaining precertification for all in-network services, when required. Participant cost share responsibilities and precertification requirements are shown on their ID card.
Connect Network A narrow network of participating providers	At enrollment, participants select a PCP from our in-network provider listing. Highlights: • PCP-coordinated care. • Referrals are required. • You are responsible for obtaining precertification for all in-network services, when required. • In-network coverage only (only emergency care is covered when received from out-of-network providers). • Coinsurance or deductibles should not be collected at the time of service. Participant cost share responsibilities and precertification requirements are shown on their ID card.
HMO Network (In-network coverage only) Point of Service (POS) (In-network and out-of-network coverage)	At enrollment, participants select a PCP from our broad network of participating physicians. Highlights: • PCP-coordinated care. • Referrals are required. • You are responsible for obtaining precertification for all in-network services, when required. • Coinsurance or deductibles should not be collected at the time of service unless you have accessed the Cigna Cost of Care Estimator® (see Cigna Cost of Care Estimator section). • Most payment responsibilities and precertification requirements for patients are shown on their ID card.

HMO Open Access Network Open Access (In-network coverage only) Point-of-Service (POS) Open Access (In- and out-of-network coverage)	Plan participants can visit specialists without a referral. You are responsible for obtaining precertification for all in-network services when required. To determine if precertification is required, please log in to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Reimbursement Policies and Payment Policies > Precertification Policies). Highlights: • Primary care provider (PCP) optional: The use of a PCP is encouraged, but not required. • You are responsible for obtaining precertification for all in-network services, when required. • In-network and out-of-network coverage (in-network utilization encouraged). • Coinsurance or deductibles should not be collected at the time of service unless you have accessed the Cigna Cost of Care Estimator® (see Cigna Cost of Care Estimator section). Participant cost share responsibilities and precertification requirements are shown on their ID card.
Indemnity	Indemnity plan participants can visit any provider. They do not choose a PCP to coordinate their care and treatment, and they do not need a referral to see a specialist. Highlights: • No provider network. • Self-directed (no PCP required). • No referral is required. • The patient is responsible for obtaining precertification for hospital admissions. • The patient or assignee is responsible for filing the claim. Deductible and coinsurance amounts are listed on the patient's ID card.

LocalPlus® and LocalPlus® IN A narrow network of participating providers	LocalPlus and LocalPlus IN plans offer access to local health care communities of in-network doctors, specialists and hospitals to employer groups (not available for individual plans). As of 1/1/2019, LocalPlus and LocalPlus IN plans are available in 24 markets in 17 states including AL, AR, AZ, CA, CO, FL, GA, IL, IN, KS, MA, MS, NV, RI, SC, TN, and TX. LocalPlus Expansion into additional states and markets is planned for 2020. The LocalPlus plan gives participants referral-free access to in-network PCPs and specialists. If participants choose an out-of-network provider, services are covered at a reduced benefit level. The LocalPlus In-Network plan also provides referral-free access to specialty care. However, participants must visit providers in the LocalPlus network to receive benefits (only emergency and urgent care is covered when received from out-of-network providers). Highlights: • PCP optional: the use of a PCP is strongly encouraged, but not required. • No referrals are required. • A local narrow network of participating providers including doctors, specialists, and hospitals. • You are responsible for obtaining precertification for all in-network services, when required. • For coverage when away from home while traveling for work or pleasure, LocalPlus provides access to LocalPlus networks in any area in the country where one exists. In areas where LocalPlus is not available, customers have coverage through Cigna's Away From Home Care feature (OAP). • Access to Cigna's national network of labs, x-rays and radiology offices, and dialysis centers. • Coinsurance and deductibles should not be collected at the time of service unless you have accessed the Cigna Cost of Care Estimator® (see Cigna Cost of Care Estimator section). • Participant cost share responsibilities and precertification requirements are shown on their ID card.

Open Access Plus (OAP) Open Access Plus In-Network (OAPIN)	The Open Access Plus plan gives participants referral-free access to PCPs and specialists. If participants choose an out-of-network provider, services are covered at a reduced benefit level. The Open Access Plus In-Network plan also provides referral-free access to PCPs and specialty care. However, participants must visit providers in the Open Access Plus network to receive coverage for covered services. (Only emergency care is covered when received from out-of-network providers.) Highlights: • PCP optional: the use of a PCP is strongly encouraged, but not required. • No referrals are required. • Broad national network of providers. • You are responsible for obtaining precertification for all in-network services, when required. • Coinsurance and deductibles should not be collected at the time of service unless you have accessed the Cigna Cost of Care Estimator® (see Cigna Cost of Care Estimator section). Most payment responsibilities and precertification requirements for patients are shown on their ID card.
PPO and EPO Self-directed health care	PPO plan participants have both in-network and out-of-network coverage. You are responsible for filing the claim form and for obtaining precertification for all in-network services, when required. EPO plan participants have in-network coverage only. Emergency and urgent care is covered in-network. You are responsible for obtaining precertification for all in-network services, when required. Highlights: • No PCP selection required. • No referrals are required. • Broad network of providers. • Coinsurance and deductibles should not be collected at the time of service unless you have accessed the Cigna Cost of Care Estimator® (see Cigna Cost of Care Estimator section). • Most participant payment responsibilities and precertification requirements for patients are shown on their ID card.

Tiered-Benefit Solutions and Physician Profiles Availability depends upon state approval for benefits and/or funding arrangement	Cigna's tiered-benefit options is available to employer-sponsored group health plans for their employees with Cigna Open Access Plus (OAP) or Preferred Provider Organization (PPO) coverage. It is intended to encourage participants with this plan feature to consider using a provider who has received the Cigna Care Designation (CCD). Choosing a CCD provider can afford a lower copayment or coinsurance for services provided than if they select a participating, non-designated provider. The designation is available in 74 service areas and distinguishes physicians in 21 specialties (3 primary care and 18 other specialties) who participate in our network, based on their meeting Cigna's quality and cost-efficiency measures. Cigna Care-designated physicians are identified in the online provider directory on Cigna.com and myCigna.com by the symbol. We evaluate physician quality and cost-efficiency information by using a methodology consistent with national standards and incorporating physician feedback. Using this information, we are able to provide our customers and clients with relevant consumer-oriented information through the physician quality and cost-efficiency displays and the Cigna Care Designation program. • Please note that physician reimbursement is unchanged whether or not a participating physician has the designation under this program.
Log in to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Medical Resources > Medical Plans and Products) for additional information regarding Cigna benefit plans and products.	

Cigna Products

Cigna Choice Fund®

Cigna offers two Cigna Choice Fund® options, a Choice Fund Health Reimbursement Account (HRA) and a Health Savings Account (HSA). These plans package a health care fund account with a Preferred Provider Organization (PPO) or Open Access Plus (OAP) medical plan that has a deductible, coinsurance, and out-of-pocket maximum.

When claims are processed, you may be reimbursed directly from the patient's HRA or HSA account for the participant's coinsurance and deductible (if funds are available). This reduces the need to collect funds from the patient at the point of service.

What you need to know

- Preventive care visits and services are paid at 100 percent for most Choice Fund medical plans, with no participant cost share applicable.
- These plans typically do not include copayments.
- Most individuals with a Cigna Choice Fund HRA plan have automatic claim forwarding (ACF). In these cases, the health account is automatically accessed to pay you directly (when funds are available). This helps to alleviate you from having to pursue the participant for any applicable coinsurance or deductible payments.
- The amount that a patient owes is determined by the claim adjudication under the terms of the medical plan.
- If the patient has ACF, collecting coinsurance and deductibles may cause an overpayment, resulting in a refund owed to the individual. Coinsurance and deductibles should not be collected at the time of service unless:
  - You have accessed the Cigna Cost of Care Estimator® to obtain an estimate of the patient's deductible and coinsurance obligations; and
  - You have provided a copy of the estimate to the patient.

For more information, including information about ACF, please visit Cigna.com/health/provider/medical/ccf.html or call 800.88Cigna (882.4462).

Cigna debit card transactions

The Cigna debit card should be used only for "medical care" expenses as defined in Internal Revenue Code section 213(d). Your patients may use their Cigna debit card to pay for eligible Section 213 medical care expenses through their Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA).

When a patient presents a Cigna debit card, the card should not be used for non-eligible medical care expenses, such as cosmetic procedures. When a patient uses their debit card for their in-network provider visits, substantiating these claims helps to improve their experience and speed up how quickly you are paid.

If the transactions are not eligible per IRS regulation, the patient should be asked to provide a separate/additional form of payment. Additional information about eligible transactions can be found at Cigna.com/expenses or http://www.irs.gov/publications/p969/index.html. You can also call Cigna Customer Service at 800.88Cigna.

ID cards – quick guide

Quick Guide to Cigna ID Cards	CignaforHCP.com > Resources > Using ID Cards.

"G" ID cards

Some participant ID cards include a "G" in the upper right corner. Service channels, including customer service numbers and claim appeal addresses, may be different for customers with these ID cards. For best results, use the service channels outlined in this Reference Guide or follow the information on the ID cards.

Strategic alliances

Some of your patients may have a plan offered through a Cigna strategic alliance. This means Cigna and another health plan jointly market benefit plans or share in the administration of the plan (e.g., we may perform claim re-pricing and other services). Participants in these plans can access in-network care through the alliance plan's network of participating providers in the alliance plan's select geographic area. In other locations, participants access care through the Cigna network.

Please refer to the customer's ID card to determine how to verify eligibility and benefits, obtain precertification, and submit claims for them.

CareLink℠ (Alliance with Tufts Health Plan)

Effective: August 1, 2005 **Service Area:** Massachusetts and Rhode Island

Contract Information:
Participants with a CareLink logo on their ID card have access to the Tufts Health Plan provider network in MA and RI for in-network coverage. Providers in MA and RI who are contracted only with Cigna are considered out-of-network for CareLink participants.

Outside MA and RI, CareLink participants have access to the Cigna national network of participating providers.

Additional Information:
You can contact Tufts Health Plan at 888.884.2404 or by visiting https://tuftshealthplan.com/provider. The CareLink (Tufts Health Plan) Quick Reference Guide is available on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Reference Guides > Medical Reference Guides > CareLink [Tufts Health Plan] Quick Reference Guide).

Health Alliance Plan (HAP)

Effective: October 1, 2005

Service Area: 20 counties in Michigan: Arenac, Bay, Genesee, Huron, Iosco, Isabella, Jackson, Lapeer, Livingston, Macomb, Monroe, Oakland, Ogemaw, St. Clair, Saginaw, Sanilac, Shiawassee, Tuscola, Washtenaw, and Wayne

Contract Information:

Providers in this service area must be contracted through HAP to be considered in-network. Outside the state of Michigan, HAP participants have access to the Cigna national network of participating providers.

Additional Information:

You can contact HAP customer service at 888.999.4347 or by visiting www.hap.org. The Health Alliance Plan (HAP) Quick Reference Guide is available on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Reference Guides > Medical Reference Guides).

HealthPartners

Effective: January 1, 2007

Service Area: Minnesota, North Dakota, Western Wisconsin

Contract information:

Providers in this service area must be contracted through HealthPartners to be considered in-network for Cigna participants. Outside the service area, HealthPartners participants have access to the Cigna national network of participating providers, except in South Dakota, Iowa, and Nebraska.

Additional Information:

The Quick Reference Guide is available online at https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/entry_142402.pdf \. The guide is also available on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Reference Guides > Medical Reference Guides > HealthPartners Quick Reference Guide).

VP Health Care

Effective: July 1, 2007

Service Area: 46 counties in Upstate New York and Bradford C
Pennsylvania beginning on January 1, 2019

Contract Information:

Providers in this service area must be contracted through MVP to be considered in-network. Outside the service area, MVP participants have access to the Cigna national network of participating providers, except in Vermont, one county in Massachusetts, and six counties in lower New York (metropolitan NYC).

Additional Information:

You can contact MVP at 888.687.6277 or by visiting www.mvphealthcare.com.

The MVP Health Care Quick Reference Guide is available on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Reference Guides > Medical Reference Guides).

Shared administration

Cigna participants only

Taft-Hartley/Federal Government: Cigna contracts with Taft-Hartley trusts and federal employee health benefit plans to share the administration of their self-funded, administrative service only (ASO) plans. For these relationships, Cigna provides access to its network, performs inpatient medical management (and sometimes outpatient, depending on the client), and/or re-prices claims according to negotiated rates. For some of these clients, Cigna may also provide stop loss insurance, disease management services, and pharmacy benefits. Third party administrators (TPAs) or the staff of these clients are also involved in the administration of these plans with respect to eligibility and claim payment on their own systems.

- Cigna requires TPAs to provide frequent eligibility information updates to help minimize late identification of non-covered employees.
- Plan designs require an in- and out-of-network benefit difference to encourage patients to use Cigna participating network providers.
- Cigna performs pre-contract checks to help ensure TPAs meet our standards for claim payment accuracy, payment turn-around time, and call statistics (e.g., average speed of answer). Additionally, adherence to these standards is a contractual requirement.
- Cigna audits all TPAs regularly to monitor compliance with contract standards.
- Cigna's network staff and our Provider Service Representatives are available to support you and facilitate resolution of any claim inquiries or issues.
- Cigna retains the authority to resolve differences regarding provider contract language and intent.
- Participants with Medicare as their primary coverage are not enrolled in these plans.

In these instances, please submit claims directly to Medicare.

For additional information, please log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Medical Resources > Medical Plans and Products > Shared Administration).

ID cards: ID cards contain the Cigna logo and both paper and electronic claims submission addresses (note: electronic claim submission is the most cost-effective method). The Cigna precertification telephone number along with the TPA telephone number and address for eligibility, benefits, and claim status inquiry are also available on the participant's ID card.

Medical management: All inpatient utilization review for acute, rehabilitation, and skilled nursing and case management is provided through Cigna and branded as CareAllies®. Clients may purchase review of outpatient services (e.g., ambulatory surgery, high-technology radiology, etc.). Participants are aware of these requirements.

Eligibility/benefits/claim status and payment: For information related to these topics, please contact the TPA telephone number and address listed on the participant's ID Card.

Claim flow: Please submit claims directly to Cigna using the Cigna electronic payer ID 62308 or to the mailing address listed on the participant's ID card. Cigna prices the claim based on your contracted reimbursement rate and the results of our utilization review program. The priced claim is then forwarded to our Shared Administration clients for payment, based on the participant's eligibility and benefits. The Shared Administration client then remits payment following contractually agreed-upon turnaround requirements. Please contact the TPA directly to enroll with Electronic Remittance Advice (ERA) and Electronic Fund Transfers (ERA).

Clinical and contract-related appeals: Please submit appeals of clinical denials to Cigna using the contact information supplied in the denial letter(s). Please submit appeals of application-of-contract rates directly to Cigna, ATTN: Appeals, P.O. Box 188004, Chattanooga, TN 37422.

Payer solutions segment

Cigna contracts with TPAs, selected insurers, and claim administrators (referred to collectively as "payers") to share the administration of their self-funded (ASO) and insured plans. For these relationships, Cigna provides access to the PPO, OAP, and LocalPlus networks, may perform medical management, and prices claims according to our negotiated rates. For some clients, Cigna also provides stop loss insurance, chronic condition management, and pharmacy benefits as well as other products. Our contracted payers maintain eligibility, administer benefits, and process claims for these accounts on their own systems.

- Cigna requires payers to provide frequent eligibility information updates to minimize late identification of non-covered employees.
- Plan designs require an in- and out-of-network benefit differential to encourage participants to use providers who participate in the Cigna network.
- Cigna performs a pre-contract review to help ensure, among other things, payers meet our standards for claim payment accuracy, payment turn-around time, and call statistics (e.g., average speed of answer). Additionally, adherence to these standards is contractually required.
- Cigna meets regularly with payers to review service metrics and may audit payers to help ensure compliance with contract requirements standards. Cigna also monitors service levels through routine metric reporting.

- The customers enrolled through these payers are “Participants” as defined by your agreement with Cigna. Additionally, Cigna has a direct agreement with the employer groups or insurers responsible for funding claim payments.
- Cigna's contracting staff and Experience Consultants are available to support providers with contracting questions. For claim-related inquiries, please contact the TPA listed on the customer’s ID card.

Claim flow: Please submit claims directly using the Cigna electronic payer ID 62308 or to the claims mailing address on the participant’s ID card. Cigna prices the claims based on the Cigna network contracted rates. The priced claim is then forwarded to the payer for payment based on the participant’s eligibility and benefits. The payers then remit payment following contractually agreed upon turnaround requirements.

Eligibility/benefits/claim status and payment: For information related to these topics, please contact the TPA telephone number and address listed on the participant’s ID Card.

Clinical and contract-related appeals: Please submit appeals of clinical denials to Cigna using the contact information supplied in the denial letter(s). Please submit appeals of application-of-contract rates directly to the address on the participant’s ID card.

Cigna Collaborative Care®

Rewarding better health, affordability, and patient satisfaction

The Cigna Collaborative Care programs are our approach to achieving the same population health goals as accountable care organizations: To help our customers gain better health, lower medical costs, and improve satisfaction.

To help attain these goals, we work with providers from across the delivery spectrum, including large physician groups, specialty groups, and hospitals. Our programs go beyond simple contracting arrangements administered in accordance with Cigna's policies and procedures to help lower costs. They include financial incentives for providers to cost-effectively provide quality care. While Cigna's collaborative care programs are designed to encourage the appropriate utilization of care, they are not intended to be a substitute for a provider's medical judgment or decision-making, nor are they intended to incentivize withholding any medically necessary care.

How we collaborate

We collaborate with providers to aid them in improving the quality and cost of care for our customers. We provide them the following resources and support to help achieve these meaningful results through these tools:

- Relevant, patient-specific information: We share patient-specific clinical data, such as potential gaps in care, recent hospitalizations, emergency department visits, medical and prescription utilization, and more. This allows Cigna to help identify for providers their aligned participants who may have possible health risks and potential to drive high costs, so the providers know where they may want to take action to help lower costs and improve health outcomes.
- Relevant provider information: We share high-level participating provider cost data. This allows the provider group and entities with which we collaborate to refer patients to the Cigna participating providers that are most likely to provide the most cost-effective care.
- Clinical resources: We help physicians identify specific quality and cost performance improvement opportunities and offer tips and suggestions to help drive better outcomes
- Clinical support programs: We make it easier for physicians to connect their patients with Cigna coverage to available Cigna health advocacy programs – such as behavioral health, case management, and disease management – to help improve their patients' health.
- Embedded Care Coordinators: We empower and train members of the physician staff to serve as dedicated patient/customer care coordinators in the Primary Care Collaboratives. These Embedded Care Coordinators work hand-in-hand with the Cigna team to plan and coordinate evidence-based care plans, and follow up to help ensure those plans are being followed.
- Learning collaborative sessions: We hold joint meetings to let physician groups share with Cigna their best practices, brainstorm ideas, give and receive feedback from their peers, and learn how we can support them.

For more information about our Cigna Collaborative Care programs, please contact your Market Medical Director or contracting contact.

Digital Solutions for Providers

We want to help you make the most of your time and provide convenient tools to handle the administrative details of health care.

Use our eService tools to access the information you need – when you need it.

Quick Summary of Key Tools	
Cigna for Health Care Professionals website (CignaforHCP.com)	This site offers secure, easy, and convenient access to eligibility, benefits and claims status information, precertification inquiry and submission, forms, policies and procedures, online learning, and more.
Cigna Cost of Care Estimator®	• Provides personalized estimates of the amount your patients may owe for specific medical and behavioral services. • Helps facilitate financial discussions between you and your patients in Cigna-administered or insured medical and behavioral plans so payment arrangements can be made before treatment. • Helps your patients understand their financial obligation, increasing the potential for payment of out of pocket expenses. • The printed Explanation of Estimate clearly illustrates “the math” and helps educate your patients about the ways their Cigna medical and behavioral benefits influence what they may owe. • Available on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Patients > Search Patients > Select a Patient > Estimate Costs). • The tool can be used with your patients enrolled in any of these Cigna-administered plans: – Preferred Provider Organization (PPO) – Exclusive Provider Organization (EPO) – Managed care plans (HMO, Network EPP, HMO Access, Network Open Access, HMO POS – Flex, Network POS – DPP, HMO POS Open Access, Network POS Open Access, Open Access Plus (OAP), Open Access Plus In-Network (OAPIN) and LocalPlus) – Choice Fund plans – Behavioral plans
Electronic Data Interchange (EDI)	EDI links your computer or practice management system with Cigna’s systems, as well as with other health plans and government payers, to exchange health care information. You can submit claims, access eligibility, benefits, and claim status information, submit precertification requests, or obtain an electronic remittance advice (ERA).

Quick Summary of Key Tools	
Electronic Funds Transfer (EFT)	EFT, also known as direct deposit, offers a secure method for funds to be deposited directly into your bank account for fee-for-service and capitated payments. Reimbursement payments are available the same day the deposit is electronically transferred to your bank account. Access a calendar for payment dates here.
Online Remittance Reports	If you are enrolled to receive payments using electronic funds transfer (EFT), you can: • Look up a remittance report using various search options • View each claim within the deposit, including the service line detail, paid amount, and patient responsibility amounts • Search within the remittance report for specific patients or claims Access to remittance reports is available on the Cigna for Health Care Professionals website (CignaforHCP.com > Remittance Reports).
Interactive Voice Response 800.88Cigna (882.4462) Applies to Cigna participants only 866.494.2111 Applies to participants with "G" ID cards only	This interactive voice response telephone system provides access to eligibility, benefit and claims status information, precertification information, credentialing status, and more.
Online Learning: eCourses	Provide convenient access to learning material about Cigna policies and procedures, electronic service capabilities, and other important information. Available to view electronically or download and print from the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > eCourses).
Pharmacy Tools	Access through your EMR or EHR.
ePrescribe	Provides access to prescription eligibility, and drug list and medication history, for your patients covered by Cigna-administered pharmacy benefits, and the ability to send electronic prescriptions to pharmacies.
ePa	For drugs that require prior authorization, you can speed up the process by submitting your request electronically.
Real Time Benefit Check	You can access patient-specific drug details through real time benefit check (e.g., quantity limits, step therapy, out-of-pocket costs, lower-cost and/or those not requiring prior authorization).

The Cigna for Health Care Professionals website

The Cigna for Health Care Professionals website (CignaforHCP.com) has been designed with YOU in mind—to fit your needs and the way you work. It provides secure, 24/7 access to participant and claim information, and includes features like auto-save and flagging that save you time and keystrokes.

On CignaforHCP.com you can access:	
Eligibility and Benefits	• Obtain specific information about your patients covered by a Cigna plan • View coinsurance, deductibles, and plan maximums • Search for up to 10 patients at once
Prescription drug list	• View Cigna's prescription drug list that offers coverage of a wide-range of brand name and generic medications. • View what drugs are currently covered on your patient's drug list.
Estimate Your Patient's Out-of-Pocket Costs	• Determine the potential total cost of a medical or behavioral service or treatment • Determine how much Cigna estimates it will pay for the service or treatment • Provide an estimate of what your patient will owe out-of-pocket
Online Precertification	• View the status of requests made by phone, fax, or online (Cigna participants only) • Get an immediate response to your request (Cigna participants only)` • Learn if precertification is required for your patient covered by a Cigna medical plan
Claim Information	• View claim status • View service line details for each claim, including amount not covered, coinsurance, patient responsibility, and service line remark codes • View payment information, including claim paid amount, check number, date issued, payment method, and date
Electronic Funds Transfer (EFT)	• Enroll in EFT • Check the status of your EFT enrollment • Change EFT settings • Change your report delivery preferences

Online Remittance Reports	• Available for providers enrolled in electronic funds transfer (EFT) • Allows you to access your remittance report the same day you receive your EFT • Easily store and search payment information and share it with your office staff
You can also:	• Find the claim submission address for a patient • Request fee schedules • Request a copy of your contract • View Cigna policies and procedures • Email specific questions about covered services and coverage criteria • View claim coding edits • View frequently submitted code combinations • Access online learning

To register and begin using the Cigna for Health Care Professionals website:

1. Go to CignaforHCP.com
2. Click **"**Register Now**"**
3. Follow the registration process

You can also contact your group's website access manager. The role of the website access manager includes:

- Obtaining access for and approving new users
- Assigning or modifying the website functions to which users have access
- Removing users' access
- Accessing users' history reports

Each group registered on CignaforHCP.com is required to assign at least one, and up to 15, user(s) as the website access manager(s). The website access manager at each practice manages how providers within the group register for and obtain the appropriate level of access to the website.

If there is no website access manager at your group, we will validate the information you provide during registration. You will receive immediate access to certain functions on the website.

If we are unable to validate the information you provided, or if there is an error in your registration, you will receive a call within five to 10 business days to activate your registration.

Online precertification using the Cigna for Health Care Professionals website or Cigna at NaviNet.net

Using our online precertification tool can help you spend less time on the phone or printing and faxing paperwork.

Get answers fast

- Learn if precertification is required for a covered medical service
- Submit and check the status of precertification requests for the following:
  - Inpatient medical services
  - Certain outpatient medical services, when required
- Get an immediate response and tracking number for all your precertification requests – some may get immediate approval. You will receive one of these responses:
  - Service does not require precertification
  - Approved
  - Pended – response includes the reason the request is pended, and a tracking number for future inquiries. Requests are reviewed within five business days or sooner if required by state or federal law. For more complex medical services, you may be asked to submit additional clinical information. If your coverage request is denied, you will receive notification, including the reason for denial and how to appeal the decision.
- Print responses for your patient records
- Available for Cigna participants by logging in to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Patients > View & Submit Precertifications)

Check the status of your request any time

No matter how you submit your precertification request—online, by fax, or by phone—you can view the status of a previously submitted request online using the precertification tracking number or member name.

Note: Online precertification is currently not available for behavioral health, substance use disorder, or dental requests. If precertification of certain services is delegated to a third party (such as high-tech imaging), you will be directed appropriately.

Access online precertification through:

- Cigna for Health Care Professionals website (CignaforHCP.com)
  - If you are registered as a Primary Administrator for the Cigna for Health Care Professionals website, you have automatic access to the online precertification feature. Simply log in to CignaforHCP.com > Patients > View & Submit Precertifications.
  - If a Primary Administrator in your office delegated access to you through the Assign Access feature, ask your Administrator to update your access to include precertification through the Modify/Delete user information option.
  - If you are not registered to use the website, go to CignaforHCP.com and click **"**Register Now**."**
- Cigna at NaviNet.net
  - NaviNet® is an easy-to-use, multi-payer website that links you to leading health plans, including Cigna.
  - If you do not have access to the online precertification feature, ask your NaviNet

Security Officer to give you access.
- To find your Security Officer, log in to NaviNet.net and click “My Profile” from the NaviNet Central menu.
- If you are not registered to use NaviNet, go to NaviNet.net and click “Sign Up.”
- For questions related to transactions, to add or edit providers in your office, or to register, call NaviNet Customer Care at 888.482.8057

Online remittance reports

If you are enrolled to receive payments from Cigna using electronic funds transfer (EFT), you can access remittance reports online that explain your processed claims, such as direct deposit activity reports (DDARs), or checkless explanations of payment (EOPs). The Remittance Reports search tool allows you to:

- View your remittance reports online the same day you receive your EFT
- Easily reconcile payments using a single remittance tracking number on your EFT report, electronic remittance advice (ERA), or online remittance report
- Look up a remittance report using several options:
  - Deposit Amount: Search for a specific deposit amount or deposits made within a specific date range
  - Patient Information: Search for a specific patient
  - Claim/Reference Number (the Cigna-assigned claim/reference number located on your EOP, claim remittance advice, DDAR, and provider explanation report)
  - Remittance Tracking Number (the number Cigna assigns to your EFT; the remittance tracking number is included on the EFT file to the bank)
- View each medical claim within the deposit, including the service line detail paid amount and patient responsibility amounts.
- Search within the remittance report for specific patients or claims.

If you are already registered for the Cigna for Health Care Professionals website and have access to claims status inquiry, you automatically have access to online remittance reports.

Primary Administrators: If you have staff that will need access to online remittance reports, log in to CignaforHCP.com > Working with Cigna > Modify Existing Users/Add New Users.

If you are not yet registered for the website, go to CignaforHCP.com and click **“**Register Now.**”** Once you complete the registration information and it has been validated, you can access your remittance reports.

Cigna Cost of Care Estimator®

The Cigna Cost of Care Estimator is an electronic tool available on the Cigna for Health Care Professionals website (CignaforHCP.com). The Estimator gives providers the ability to create an estimate of their patient’s payment responsibility specific to that provider and the treatment or service, based on a real-time snapshot of the participant’s Cigna-administered benefits. It helps eliminate financial surprises by estimating the cost of the medical or behavioral service, highlighting the participant’s anticipated payment responsibility, and providing you and your patients with an itemized, printable Explanation of Estimate. It is fast

to use, easy for your patients to understand, and can be used anytime during your patient's visit: prior to care, at check in, or at checkout.

By entering the CPT code(s) or identifying information about the procedure along with the plan participant's Cigna identification number and date of birth, you will receive a personalized Explanation of Estimate that contains the following information:

- Total cost of the service
- Plan participant's deductible/coinsurance/copay responsibility
- Plan participant's anticipated payment from their health account (HSA, HRA, FSA) when automatic claim forwarding is enabled
- Plan participant's estimated amount owed out-of-pocket

The Estimator is available to participating providers in the Cigna network. To use it, log in to CignaforHCP.com > Patients > Search Patients > Select a Patient > Estimate Costs.

The estimate you receive represents your patient's anticipated out-of-pocket expense if the services billed are covered under their medical plan. It does not guarantee coverage or payment, but allows you to have a financial discussion with your patient and set realistic financial obligations for them.

Electronic data interchange (EDI)

EDI allows patient information to be transferred between you and Cigna in a standardized, secure way, and makes it available right on your desktop.

Use your existing EDI vendor, practice management software, or account receivable software to connect with our systems to:

- Submit electronic claims to Cigna (837), including coordination of benefit (COB) claims, and receive an electronic claim acknowledgment (277CA)
- Receive payment information in the electronic remittance advice (835), including the amount paid and when the check or electronic funds transfer (EFT) was issued
- Submit electronic eligibility and benefit inquiry (270/271) and track claim status (276/277) through your EDI vendor
  - Receive a real-time response in seconds
  - Obtain benefit information, including preventive care, vision, maternity, infertility, allergy injections, and well-child care
  - Receive remaining health plan deductible and coinsurance amounts
  - Obtain coordination of benefits and shared administration or alliance information
  - Obtain claim status and receive responses using the HIPAA standard health care claim status codes
- Submit electronic health service review/precertification requests (278)

Electronic transaction support

For a list of EDI vendors and transactions they support, visit Cigna.com/EDIvendors. For questions about transactions submitted through your EDI vendor, please contact the vendor directly.

Cigna payer ID for submitting electronic claims

Payer ID	Claim type
62308*	Medical, behavioral (including employee assistance program), dental, and Cigna-HealthSpring Arizona Medicare claims

*Both primary and secondary (COB) claims can be submitted electronically to Cigna.

You don't have to submit Medicare Part A and B coordination of benefits agreement (COBA) claims to Cigna, as the Medicare explanation of benefit (EOB) or electronic remittance advice (ERA) will show that those claims are forwarded to Cigna as the secondary payer.

Cigna toll-free telephone numbers

- 800.88Cigna (882.4462) – for your patients with Cigna ID cards
- 866.494.2111 – for your patients with "G" ID cards

The above numbers offer access to eligibility, benefit, and claim information. You may use our interactive voice response (IVR) automated telephone system or speak to a Cigna Customer Service Representative.

You can receive eligibility and benefit information for multiple patients during a single phone call. When using the IVR, you have the option of hearing the requested information or having it faxed to you.

You may also submit requests for precertification, referrals, and/or prescription authorizations. Detailed claim information is available, such as claim status, payee, check amounts, and when and where payments were sent.

Cigna IVR user tips

- Press "*" to repeat information just heard or repeat menu options.
- During menu options, press "9" to go back to the main menu.
- After accessing the self-service information (such as eligibility, benefits, and claim status), press "0" to speak with a Cigna customer service representative.
- Press "#" after entering data values (e.g., patient identification number or date of birth).

ePrescribe

ePrescribing is available to providers for your patients covered by Cigna-administered pharmacy benefit plans. ePrescribing provides access to prescription eligibility, drug list and medication history, and allows prescriptions to be sent electronically to a patient's pharmacy of choice, including Express Scripts Pharmacy, our home delivery pharmacy. . ePrescribing can be used during point of care and prescriptions can be sent before the patient leaves the office.

ePrescribing provides:

- Significant patient safety advantages, including the ability to check for drug allergies or whether a prescription may conflict with another medication

- Access to information that allows for review of medication efficacy and dosage adherence
- Access to the Cigna drug list
- Administrative efficiencies by eliminating the need for written, telephone or fax delivery of a prescription and subsequent phone calls to clarify handwritten prescriptions or renew a prescription

Online training and resources

Cigna offers online learning about our electronic capabilities, timely health care topics, and other important information. No special software is required. You can view any of the materials electronically at your convenience, or simply download to your computer to review later or share with your staff. .

Online training materials are available on the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Medical Education and Training).

Cultural competency

Diversity within the general population is anticipated to increase in future years. As the population continues to diversify, you may face increasing challenges in providing quality health care to all of your patients. Increased awareness of diversity will help you identify opportunities to collaborate with your patients.

By being culturally competent in health care, providers can understand their patients' diverse values, beliefs, and behaviors, and customize treatment to meet their patients' social, cultural, and linguistic needs.

Cigna offers resources that can help create an optimal experience for providers, staff, and patients who may face cultural barriers. These resources are available on Cigna.com and CignaforHCP.com. You will be able to access links to resources at no extra cost. Resources include articles, training, videos, a health equity brochure, as well as a powerful public service announcement on the importance of language interpreters in health care.

Visit either of these websites to learn more:

- Cigna.com > Health Care Professionals > Resources for Health Care Professionals > Health & Wellness Programs > Cultural Competency Training and Resources
- CignaforHCP.com > Resources > Medical Resources > Doing Business with Cigna > Cultural Competency Training and Resources

Provider Participation

In our role as a health service company, Cigna contracts with physicians, physician groups, associations and delivery systems, hospitals, ancillary practitioners, and facilities so that our customers can obtain the care they need cost-effectively—for both primary and specialty care. In most situations, our customers expect to receive care from Cigna-participating providers across the entire care access spectrum in order to maximize their in-network benefits, even when their doctor refers them elsewhere.

As part of your contract with Cigna, you agree to refer your patients to other in-network contracted physicians, hospitals, and other providers and facilities. Naturally, there are some exceptions, for example, in an emergency or if services cannot be provided within the network. However, Cigna has made significant investments in online tools, smartphone apps, and 24-7 customer service to help individuals make informed decisions about their care and costs so they can “know before they owe.” It is Cigna's expectation that you will partner with Cigna customers to help them maximize their benefits by referring additional care to other participating providers.

As a Cigna participating provider, you must provide services with the same standard of care, skill, and diligence customarily used by similar health care providers in your community, the requirements of applicable law, and the standards of applicable accreditation organizations. All services that are provided within the scope of your practice or license must be provided on a participating basis. Regardless of your physical location, all aspects of your practice are participating under the terms of your participation agreement if any part of your practice is participating unless services are provided under the terms of another applicable Cigna participation agreement or a contractual exception applies. Services you provide to Cigna participants should be done in the same manner, under the same standards, and with the same time availability as offered to other patients. You will not differentiate or discriminate in the treatment of any Cigna participant based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, veteran’s status, handicap, or source of payment.

Further, as a participating provider, you must meet the Cigna credentialing standards for training, licensure, and performance before joining the network. You will also be evaluated periodically to help ensure continued qualification. Performance requirements include providing quality services to participants and cooperating with Cigna administrative, quality, and medical management programs. Cigna evaluates performance data for quality improvement activities, preferred status designation in Cigna's network, and reduced customer cost sharing, as applicable.

Primary care provider services

The primary care provider (PCP) coordinates care for participants who choose a PCP. Coordinating a participant’s care can include providing treatment, referring to participating specialists or other providers, and requesting precertification of coverage.

A PCP may practice in the field of family practice, general medicine, internal medicine, or pediatrics. Other specialties may be designated as PCPs depending upon state laws.

For managed care plans, participants are required or encouraged to select a PCP to manage their health care needs.

PCPs must comply with Cigna medical management programs, including utilization management, quality management, preventive care guidelines, and prescription drug programs.

Specialty care physician services

The specialty care physician (SCP) provides specialty medical services to participants with Cigna coverage referred by a PCP or selected by the participant in accordance with plan benefits.

An SCP coordinates the Cigna participant's care with the PCP to ensure compliance with Cigna's medical management requirements. This includes verifying referrals or precertification requirements before treating participants (if applicable), referring requests back to the PCP for additional services or referrals to other participating SCPs, and communicating findings and treatment plans to the PCP on a timely basis.

An SCP accepts referred participants from participating providers and renders services as appropriate. The SCP must comply with Cigna medical management programs, including utilization management, quality management, and prescription drug programs.

Service standards and requirements

Participants in Cigna-administered or insured plans expect quality health care services. You can assist us in maintaining access to quality service by adhering to the following standards and requirements. Compliance with these standards may be monitored through site visits, medical record reviews, and participant surveys.

Acceptance and transfer of participants

You should not refuse or fail to provide services to any participant unless you are incapable of providing the necessary services or as otherwise provided in the Closing a PCP Panel section that follows. You are expected to provide services to participants in the same manner, in accordance with the same standards, and with the same time availability as provided to other patients.

Closing a PCP panel

Cigna encourages PCPs to have a large Cigna participant panel whenever possible.

If you are a PCP for one of our PCP-coordinated plans, you may close your panel to new participants with Cigna coverage under several conditions. When closing a PCP panel, **you must**:

- Notify Cigna 30 days in advance of closure – 800.88Cigna (882.4462)
- Have closed your practice to all new patients

- Accept all participants paneled to you before your panel closure even if the participant has not yet been seen by your practice
- Accept existing patients who were previously covered by another health plan

Participant removal from a PCP panel
If you are a PCP for one of our PCP-coordinated plans, you may request a patient be removed from your panel. Requests are evaluated according to Cigna's criteria for removal of a participant. You must provide the patient 30 days advance written notice of a transfer and continue to provide necessary covered services to the patient until the change is completed.

A request to have a participant choose another physician should be based on unmanageable personality differences or related conflicts, and not on patterns of utilization or diagnosis. You have the right to request removal of a participant from your panel when the participant:

1. Permits another individual without Cigna coverage to use a Cigna participant ID card to obtain services and benefits.
2. Obtains or attempts to obtain services or benefits by means of false, misleading, or fraudulent information, acts, or omissions.
3. Repeatedly fails to pay copayments, coinsurance, or deductibles required under the plan.
4. Is unable to establish a satisfactory physician-patient relationship after a strong effort by the physician to establish such a relationship.
5. Exhibits disruptive, unruly, abusive, or uncooperative behavior, such that your ability to provide services to the participant or to any other participant is seriously impaired.
6. Threatens the life or well-being of you or your staff.

Communication to participants of professional termination
If your participation with Cigna is terminated entirely or with respect to any of our benefit plan types, Cigna will notify affected participants of the termination to the extent required by applicable law and applicable accrediting requirements. Such notification will occur before the effective date of the termination unless Cigna does not receive sufficient advance notice. In this instance, Cigna will notify affected participants to the extent required as soon as reasonably possible. Upon request, you are responsible for providing a listing of participants affected by your termination within seven business days of the date of the notice of termination.

In the event you decide to send any written communication to participants regarding your Cigna participation or use our name in such manner, we reserve the right to review and approve the communication prior to release. You may not make any disparaging comments about Cigna or misrepresentations in any communications regarding your participation with Cigna. Refer to your provider agreement for more information.

Office hours and accessibility
Participants must have access to medical care within a reasonable length of time.

You must have scheduled office hours for at least 24 hours per week. PCPs and SCPs must be available to provide services to participants 24 hours per day every day of the year. Best efforts must be made to ensure a Cigna participating provider is on call and available when the office is closed.

There must be a publicized telephone number for participants to call and telephone calls must be answered promptly by a person trained in the appropriate response to medical calls of a routine, urgent, or emergent nature. Refer to Telephone Response Time section below.

Access

Outpatient Diagnostic Hours

Hospitals and ancillary facilities must have scheduled outpatient hours for routine diagnostic and supplemental services, including clinical laboratory, radiology, and physical medicine, as applicable under the provider agreement.

Hospital Hours

Hospitals must provide or arrange for necessary medical services 24 hours a day, seven days a week

Telephone Response Time

Telephone calls must be answered promptly. When it is necessary to place callers on hold, callers should be asked if they can hold and the caller should only be placed on hold after giving an affirmative response. Callers who do not wish to hold should have their calls handled as appropriate. If the phone is answered by an answering machine, the message must give emergency instructions that clearly explains how to get urgent or emergency care, and when appropriate, how to contact another provider who's on-call for triage and screening services or, if needed, to give urgent or emergency care.

Appointments and scheduling guidelines

- You should ensure participants have access to timely appointments and scheduling.
- Emergent or high-risk cases should have access to immediate appointments, appropriate emergency room authorization, or direction to dial 911.
- Urgent cases should have access to appointments within 24 hours.
- Non-urgent, symptomatic, or routine appointments should be scheduled within seven to 14 days.
- Preventive screenings and physicals should be scheduled within 30 days.
- Generally, obstetric prenatal care for non-high risk and non-urgent situations should be provided within 14 days in the first trimester, within seven days in the second trimester and three days in the third trimester.
- Wait times should generally not exceed 30 minutes past the scheduled appointment time
- When needing to reschedule an appointment, the timing of the rescheduled appointment should take into account the severity of the patient's condition so that they have timely access to necessary care and to ensure continuity of care.

Professional services
All services must be provided by duly licensed, certified, or otherwise authorized professional personnel and at facilities that comply with:

- Generally accepted medical and surgical practices
- State and federal law
- Accreditation organization standards

Cooperation with programs
Cigna is committed to promoting access to quality services for participants. To support this commitment, we require your cooperation with Cigna programs, including administrative programs such as claim appeals, wellness, and other medical management programs.

Cooperation with Cigna in establishing and implementing policies and programs to comply with regulatory, contractual or certification requirements of Healthcare Effectiveness Data and Information Set (formerly Health Plan Employer Data Information Set) (HEDIS®),* National Committee for Quality Assurance (NCQA), and any other applicable accreditation organization is equally important.

Participant billing
Copayments: A copayment is a fixed dollar amount that a participant pays per service. Copayment amounts are printed on the Cigna ID card. Collect the applicable copayment amounts on the ID card at the time of service.

Coinsurance and deductibles: For participants with plans that have deductibles or require participants to pay a percentage of the covered charges (coinsurance) after satisfying any deductible amount, you should submit claims to Cigna or its designee and receive an explanation of payment (EOP) indicating the participants' responsibility before billing patients. Coinsurance and deductibles should not be collected at the time of service unless you have accessed the Cigna Cost of Care Estimator® to obtain an estimate of the deductible and coinsurance obligations of the plan participant, and provided a copy of the estimate to the participant at the time of service.

The Cigna Cost of Care Estimator® can inform you and your patients that participate in Cigna medical or behavioral plans of their estimated financial responsibility for services based on their specific Cigna-administered plan. The Estimator is available for all plan participants in Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO) , Open Access Plus (OAP), and Open Access Plus In-Network (OAPIN) plans managed care plans (HMO, Network EPP, HMO Access, Network Open Access, HMO POS – Flex, Network POS – DPP, HMO POS Open Access, Network POS Open Access, Open Access Plus (OAP) Open Access Plus In-Network (OAPIN) and LocalPlus), Choice Fund plans, plans for participants with "G" ID cards, and Behavioral plans.

You can access the Cigna Cost of Care Estimator tool through the secure Cigna for Health Care Professionals website (CignaforHCP.com > Patients > Search for a Patient > Select a Patient > Estimate Costs).

For additional information about the Cigna Cost of Care Estimator, log in to Cigna for Health Care Professional website (CignaforHCP.com > Medical Resources > Doing Business with Cigna > Cigna Cost of Care Estimator®). To learn how to use the Estimator, access the Cigna Cost of Care Estimator eCourse in Resources > eCourses.

Many Cigna Choice Fund HRA plan participants have automatic claim forwarding (ACF) enabled as chosen by their employer so the deductible and coinsurance amounts they owe are paid directly out of their HRA fund. After claim processing, if funds are available, Cigna automatically sends payment to you on behalf of the Cigna Choice Fund participant, usually along with Cigna's portion of the payment. ACF is currently active on the majority of our Choice Fund HRA plan participants.

Please note for Choice Fund HSA plan participants, the ACF feature is chosen by the customer, it is now referred to as Auto Pay with our vendor, HSA Bank. The majority of the time it is not a chosen option as it is on HRA plans.

Fee forgiving/waiver of copayment/coinsurance or deductible: Most benefit plans insured or administered by Cigna exclude from the participant's coverage those charges for which the participant is not obligated to pay. Therefore, if a plan participant is not obligated to pay a charge, any claim for reimbursement for any part of that charge under such a contract or benefit plan is generally not covered. It is Cigna's view that "fee-forgiving" on any particular claim, or any portion thereof, could constitute fraud and may subject a provider to civil and criminal liability.

Participant incentives prohibited: Providers shall not directly or indirectly establish, arrange, encourage, participate in, or offer any Participant Incentive. Providers include hospitals, ancillary services, health care facilities, individual and group practitioners, and all other entities delivering covered health care services to participants.

"Participant Incentive" means any arrangement by a provider:

1. To reduce or satisfy a Participant's cost-sharing obligations (including, but not limited to Copayments, Deductible and/or Coinsurance offer a Cash Price Discount and/or Prompt Pay Discounts).
2. To pay on behalf of or reimburse a Participant for any portion of the Participant's costs for coverage (e.g., insurance premiums) under a policy or plan insured or administered by Cigna or a Cigna Affiliate.
3. That provides a Participant with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from the provider or its affiliates.

In the event of non-compliance with this provision:

1. Cigna may terminate the provider's participation agreement; as such, non-compliance is a "material breach" of the agreement.

2. The provider shall not be entitled to reimbursement under its participation agreement with respect to Covered Services provided to a Participant in connection with a Participant Incentive.
3. Cigna may take such other action appropriate to enforce this provision.

Denied payment and participant non-liability

You cannot bill participants for covered services or for services for which payment was denied due to your failure to comply with your provider agreement or Administrative Guidelines and/or Program Requirements, including Cigna utilization management requirements and timely filing requirements.

Confidentiality

Cigna maintains strict policies to protect confidential information. As a participating provider, you are responsible for maintaining the confidentiality of participant information in all settings in accordance with federal and state laws. Written policies and procedures should be established that include the designation, maintenance, release, and control of access to confidential records.

If you have questions or comments about Cigna policies, call 800.88Cigna (882.4462).

Medical records

This information pertains to hospitals and ancillary facilities

Cigna safeguards participant information and expects the same standard of you. To maintain confidentiality and privacy of participant Protected Health Information (PHI) and Personally Identifiable Information (PII), you must keep secure, accurate, and organized medical records for each patient and comply with applicable federal and state law about such records.

You must allow Cigna personnel access to participant medical records as appropriate for Cigna business purposes during normal business hours, including medical chart reviews. For electronic medical record access, if You require Cigna, its employees and/or its designee to execute a data access or data use agreement, the following shall apply and supersede any conflicting terms or conditions within such agreements: 1. Cigna employees and/or its designee may not be held individually liable by provider for any act, omission or breach of such agreements, absent any willful and wanton or criminal conduct; 2. Cigna and/or its designee are only obligated to comply with those terms and conditions applicable to it as a Payor or consistent with the access necessary to fulfill Cigna's duties and obligations under the terms and conditions of Your participation agreement with Cigna; 3. In the event of a conflict between Your policies and procedures and Cigna’s, Cigna's policies and procedures shall control with regards to Cigna's obligations; 4. As both parties are HIPAA covered entities, Your data access or use agreement shall not be construed to create a business associate relationship with Cigna and/or its designee; and 5. Cigna and/or its designee shall not be liable for any breach of data not otherwise attributable to the negligence of Cigna, its employees, or its designee. At the time of service, you must request that participants sign a routine consent form allowing for the disclosures required under the provider agreement and

these Administrative Guidelines and Program Requirements to the extent such consent or approval is required by law.

Medical record reviews

This information pertains to physicians and other providers

Physicians plan patient care and provide continuous information about the patient's medical treatment using the patient's medical records. As a permanent record, the patient's medical record informs other providers about the patient's medical history.

Medical record documentation: To help ensure participants receive effective, safe, and confidential patient care, medical records should be current, detailed, organized, and signed. Providers are asked to attest to the adherence of confidentiality practices around secure storage of medical records, access to records only by authorized personnel, and periodic training of staff in member information confidentiality. Records should, at a minimum, document these core elements:

- Updated, complete problem list or summary of health maintenance exams
- Current prescription medication list or medication notes
- A list of medications to which the patient is allergic or does not tolerate
- Review of consultant report, if requested
- Medical history
- Visit exam coinciding with chief complaint
- Examinations which identify subjective and objective information
- Documentation of treatment plan
- Review of lab and diagnostic studies
- Notation of each follow-up visit
- Allergies and adverse reactions to medication
- Consultation report, if requested
- Follow-up on prior problem addressed at each visit
- A health screening for alcohol usage
- A health screening for tobacco usage
- Advanced Directives

Note: It is important that all medical conditions are clinically supported and indicate treatment. Cigna is required to provide requested medical records as evidence of conditions and the treatment to the Centers for Medicare & Medicaid (CMS) as part of our risk adjustment program.

You must allow Cigna personnel or Cigna's designee access to participants' medical records for appropriate Cigna business purposes during normal business hours,

including medical chart review. For electronic access, if You require Cigna and/or its employees to sign a data access or data use agreement in order to obtain access to electronic participant medical records, the parties hereby agree that the following shall apply and supersede any conflicting terms or conditions within such agreements: 1. Cigna employees may not be held individually liable by provider for any act, omission or breach of such agreements, absent any willful and wanton or criminal conduct; 2. Cigna is only obligated to comply with those terms and conditions applicable to it as a Payer or consistent with the access necessary to fulfill Cigna's duties and obligations under the terms and conditions of Your participation agreement with Cigna; 3. In the event of a conflict between the parties policies and procedures, Cigna's policies and procedures shall control with regards to Cigna's obligations; 4. As both parties are HIPAA covered entities, Your data access or use agreement shall not be construed to create a business associate relationship with Cigna; and 5. Cigna shall not be liable for any breach of data not otherwise attributable to the negligence of Cigna, its employees, or its agents.

At the time of service, you must request that participants sign a consent form allowing for the disclosures required under the provider agreement and these Administrative Guidelines and/or Program Requirements to the extent such consent or authorization is required by law.

Credentialing

Credentialing for providers

Providers are credentialed before becoming a Cigna participating provider and are recredentialed periodically thereafter, to help ensure they continue to meet our qualifications for participation. Criteria for participation are determined by business needs and by our credentialing policies and procedures, reviewed annually to reflect National Committee for Quality Assurance (NCQA), local and state standards.

Follow these steps to complete the credentialing process:

To request participation contact Cigna at 800.88Cigna (882.4462)
Answer a short list of general questions so we can evaluate your request under current contracting criteria, add you to the Council for Affordable Quality Healthcare (CAQH) roster, and send you a standard contract.
Complete and submit the online CAQH application at Proview.CAQH.org.
Sign the contract and return it to the address provided in the letter.

Submitting paper forms

If you do not have Internet access, call CAQH at 888.599.1771 to request a paper application. In addition, call Cigna at 800.88Cigna (882.4462) to initiate the credentialing and contracting process.

Submitting electronic forms

Council for Affordable Quality Healthcare (CAQH) credentialing database system

Cigna is part of the Council for Affordable Quality Healthcare (CAQH), a nonprofit alliance of managed care plans, physician-hospital organizations, and trade organizations. CAQH recognizes the need to simplify administrative requirements and allow you to focus on caring for patients. Improving processes for obtaining and managing data is a key factor to saving time. Working with health care delivery systems and various technical and software specialists, CAQH sponsors the Universal Provider DataSource initiative.

This online database system, developed by managed care organizations with help from physicians, professional associations and accreditation organizations, allows providers to complete one credentialing application by entering confidential information into one, secure database that is shared, with your approval, with participating health plans and other participant organizations. Providers provide the basic information only once, and updates are made online or by fax. There is no charge to submit information to the CAQH credentialing database and CAQH contacts providers regularly to ensure the information is complete. Some states mandate the use of the CAQH application and Cigna strongly encourages its use when submitting your application in all states.

For more information about the Universal Provider DataSource, or to apply online, visit Proview.CAQH.org. For questions about completing the application, call the CAQH Help Desk at 888.599.1771 or email CAQH at Caqh.updhelp@acsgs.com.

Notice of changes

As a participating provider, you are responsible for notifying Cigna immediately of any changes to the information presented as part of the credentialing or recredentialing process. Failure to notify Cigna of changes or to satisfy requirements may result in your removal from Cigna.

Credentialing process for practitioners

The credentialing process includes a review of the standard application and independent verification of certain documentation submitted. Information submitted must be accurate, current, and complete.

Cigna's requirements for physician participation include, but are not limited to, the following:
A completed signed and dated application (dated within 180 days). Correction liquid must not be used in the signature area of paper applications. Applications with altered signatures will not be processed
A completed, signed and dated authorization and release form, if not included in the application form
A completed, signed and dated provider agreement (two originals), copy of a completed Provider Data Sheet, copy of a completed W-9, and copy of a CMS-1500 claim form with Box #33 completed (if not included on Provider Data Sheet)
Documented work history in month/year format
A current unrestricted license to practice medicine in the state where practicing
A current unrestricted DEA certificate (if applicable)
A current unrestricted CDS certificate (if applicable)
Board Certification, if applicable, in a recognized specialty by the American Board of Medical Specialties, American Osteopathic Association, American Board of Podiatric Surgery or American Board of Podiatric Orthopedics and Primary Podiatric Medicine
Review of unrestricted admitting privileges to at least one Cigna participating hospital, depending on the network in which you are requesting to participate and whether that hospital participates in that network. Exceptions may be granted (i.e., an applicant's specialty does not typically require admitting privileges, satisfactory alternative mechanism has been established as determined by Cigna, etc.).
Professional liability insurance with typical minimum coverage of $1,000,000 per incident and $3,000,000 aggregate for physicians and other providers
Acceptable history of professional liability claim experience as determined by Cigna
Completed professional liability information (with explanation of each case)
Acceptable history of Medicare/Medicaid sanctions as determined by Cigna
Acceptable responses to all questions on the credentialing application form as determined by Cigna
Acceptable report from the National Practitioner Data Bank as determined by Cigna

An acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory or other professional organization

Practitioner rights

You have certain rights during the credentialing process, including the right to:
Review information submitted to support credentialing application.* Information from outside sources (e.g., licensing boards, etc.) will be made available for review.* Providers may exercise this right by contacting the Credentialing Department at 800.88Cigna (800.882.4462).
Correct erroneous information.* When erroneous information is present, providers are contacted in writing by a representative from the Credentialing Department and notified of the discrepancy. Corrections should be submitted to the Credentialing Department in writing within 15 business days at the location as noted on the request. All responses are recorded with a date of receipt and maintained as part of the provider's credentialing file.
Receive the status of their credentialing or recredentialing application, upon request.* Providers may contact 800.88Cigna (800.882.4462) to inquire about the status. While the application review process is occurring, through discussion with a representative from Provider Services Unit, Provider Data Management, or Credentialing, depending on where the request is received, practitioners are informed of the status of their credentialing or recredentialing application. Communicating the status of the application may be done electronically or verbally. Verbal inquiries are responded to immediately whereas electronic inquiries are responded to within 15 days.
The decision to accept or deny participation will be communicated in writing within 60 days of the decision.

* References, recommendations and other peer review protected information will not be shared. All state and federal guidelines are also adhered to, where applicable.

Recredentialing process for practitioners

Cigna recredentials its participating physicians once every three years or more often if required by state law. If you have not applied through the CAQH Universal Provider DataSource, you will be mailed a recredentialing letter approximately six months before your recredentialing date. The letter will direct you to complete the CAQH Universal Provider DataSource credentialing form.

If you already completed and updated the CAQH application and attestation and authorized Cigna to receive current credentialing information, Cigna will automatically have access to your application during the recredentialing process, and will only contact you if needed. If you use a state-mandated form outside of CAQH, you must update any information that has changed, sign the attestation, and submit the application along with current supporting documents.

During the recredentialing process, completed applications are reviewed and certain new information is independently verified.

The criteria reviewed includes, but are not limited to:
A completed signed and dated application (dated within 180 days). Correction liquid must not be used in the signature area of paper applications. Applications with altered signatures will not be processed
Completed, signed and dated authorization and release form if not included in the application form
Current, unrestricted license to practice medicine in the state where practicing
Current DEA certificate number (if applicable)
Current CDS certificate number (if applicable)
Status of current board certification (if applicable)
Record of adequate education and board certification for any new specialty in which you request to be credentialed
Review of adequate admitting privileges to at least one Cigna participating hospital, dependent upon the network participation being requested and whether the hospital also participates in that network. Exceptions may be granted (e.g., a provider's specialty does not typically require admitting privileges, where a satisfactory alternative mechanism has been established as determined by Cigna, etc.).
Professional liability insurance with typical minimum coverage of $1,000,000 per incident and $3,000,000 aggregate for physicians and other providers
Acceptable history of professional liability claim experience as determined by Cigna
Completed professional liability form with explanation of each case for paper applications
Written explanation relevant to professional liability and practice review questions
Acceptable history of Medicare/Medicaid sanctions as determined by Cigna
Acceptable results from the National Practitioner Data Bank as determined by Cigna
Acceptable responses to all questions on the credentialing application form as determined by Cigna
Signed, dated and completed professional liability form (Form A)
Copy of current DEA and CDS (if applicable) certificates
Copy of current professional liability face sheet

Non-physician practitioners

Cigna credentials and recredentials non-physician practitioners in the following categories when Cigna holds a direct provider agreement with the practitioner:

Certified Midwives and Certified Nurse Midwives	Certified Registered Nurse Anesthetists	Non-Physician Acupuncturists
Naturopaths	Nurse Practitioners	Physician Assistants

This list is subject to change and is subject to state law. Credentialing and recredentialing requirements are similar to physician requirements.

Credentialing requirements for hospitals and ancillary facilities
To help ensure Cigna network providers meet Cigna quality standards for participation and to comply with accreditation requirements, hospitals and ancillary facilities are credentialed before participating in a Cigna network. Participating hospitals and ancillary facilities must maintain an ongoing quality improvement program that monitors and evaluates the quality and appropriateness of patient care, pursues improvement opportunities and resolves problems. Accrediting organizations, such as the Joint Commission (JC), validate a quality improvement program. When accreditation, state Department of Health, or Medicare certification evidence is not available, Cigna may perform a site visit and review of the hospital or ancillary facility quality improvement program.

In accordance with the Cigna national credentialing requirements, hospitals and ancillary facilities must apply for participation by completing a standard application form and satisfactorily meeting the established criteria. The Cigna credentialing and recredentialing policies and procedures are reviewed at least annually and revised as necessary, including revisions to reflect state and local quality assurance standards.

The information required to complete the credentialing process includes, but is not limited to, the following:
Copy of unrestricted state license or state operating certificate, as applicable
Copy of current accreditation letter or certificate
Proof of current professional and general liability insurance coverage that meets Cigna minimum guidelines
National Provider Identifier
Any explanation requested on application, including a list of malpractice settlements and judgments
If not accredited, a copy of the most recent Centers for Medicare & Medicaid Services (CMS) evaluation
An onsite assessment, if not accredited or Medicare and Medicaid certified
A copy of the quality management plan, if not accredited or Medicare and Medicaid certified
List of available services that can be rendered by facility
Absence of current sanctions from Medicaid or Medicare
If an ancillary facility is not subject to state licensure requirements, the Cigna credentialing committee will determine if the facility meets remaining credentialing standards for participation in the Cigna network.

Participating hospital and ancillary facilities are recredentialed every three years or more frequently if required by applicable law. Cigna credentialing staff will confirm that the

hospital or ancillary facility continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

Participating hospital or ancillary facilities are responsible for notifying Cigna immediately of any material changes to the information presented at the time of their prior credentialing or recredentialing cycle. Failure to notify Cigna of changes or to satisfy requirements may result in termination from the Cigna network. Recredentialing and continued participation in the provider network are dependent upon the hospital or ancillary facility continuing to meet the Cigna credentialing and recredentialing standards.

Termination appeal process

You may appeal our decision to terminate your Cigna participation agreement based on a:
Quality of care reason
Quality of service reason
Failure to meet our credentialing requirements, if you participate in a state and/or network with a requirement that appeal rights be offered

Submit appeals in writing within 30 days of notification of termination from the network. Refer to your provider agreement and the dispute resolution section of this Reference Guide for more information. Appeal rights will only be offered to providers terminated due to Quality of Care or Quality of Service and providers terminated in states which mandate that appeal rights be offered.

You must not make any material misrepresentations in the information provided during your contractual relationship with Cigna, including medical record information. In addition, you must continue to satisfy all of the credentialing criteria.

The credentialing documents must be current in the CAQH Universal Provider DataSource system or be submitted in a credentialing/recredentialing paper packet. If any of the documents are missing, your file cannot be processed and participation in the Cigna network may be denied or terminated.

Types of hospitals and ancillary facilities to be credentialed

The list of the types of hospitals and facilities Cigna credentials and recredentials includes, but is not limited to:	
Hospitals (acute, subacute, transitional, and rehabilitation)	Home health agencies (nursing and home infusion)
Long term care facilities (skilled nursing facilities and nursing homes)	Free-standing ambulatory surgical centers (including cardiac catheterization labs and endoscopy centers)
Hospices	
States may require credentialing of additional facility types; Cigna will adhere to state guidelines where required.	

Hospital and ancillary facility quality assurance and quality improvement program
Cigna requires participating hospitals and ancillary facilities to have an ongoing quality assurance and quality improvement program.

The program should:
Monitor and evaluate the quality and appropriateness of patient care
Pursue opportunities to improve patient care
Resolve identified problems

The program's objectives, as well as the role of the organization, should be clearly outlined, and should include a description of the mechanisms for overseeing the effectiveness of monitoring, evaluating, improving, and problem-solving activities. Additionally, the hospital or ancillary facility should identify the designated individual or group responsible for the implementation of the program.

Because Cigna's accrediting process includes assessing a quality management program, hospitals and ancillary facilities that are accredited are deemed to have a quality management program. Additionally, hospitals and ancillary facilities may also be deemed to have a quality management program if the state Department of Health conducts periodic site assessments as a prerequisite for licensing and for Medicaid and Medicare certification. However, this is only true when the state's site assessment process is equivalent to Cigna's.

The hospital's or ancillary facility's overall quality program will be assessed during the site assessment and program evaluation. For a complete list of the criteria, please contact us at 800.88Cigna (882.4462).

For more information on the quality assurance and quality improvement program, please refer to the Quality Management Program section.

Eligibility

Determining eligibility

It is important to determine patient eligibility prior to rendering service. We recommend verifying your patient's eligibility prior to their appointment date. Patients are responsible for presenting their ID card or enrollment form (if they are awaiting receipt of an ID card) as proof of coverage.

Eligibility verification

In addition to viewing your patient's ID card, you should verify eligibility by:

- Accessing our website (CignaforHCP.com > Patients > Search Patients)
- Submitting an eligibility and benefit inquiry (270/271) through your EDI vendor
- Using our automated interactive voice response (IVR) system
- Contacting a Cigna Customer Service Representative

When verifying eligibility and benefit information on the website or eligibility and benefit inquiry (270/271) through your EDI vendor, you can receive:
Eligibility status (active, inactive, non-covered)
Coverage effective and term dates
Patient insurance and plan types such as PPO, Network, or Choice Fund HRA Open Access Plus
Plan level copayment, coinsurance, deductible, and accumulator amounts
Benefit-specific copayment, coinsurance, and deductible amounts
An indicator of different benefits for in-network and out-of-network
HMO code, network ID, line of business (018, VA085, Flex) for participants covered by managed care plans
PHS, PHS+, Health Matters-Complete and Health Matters-Preferred medical management identification
Coordination of benefits information (Medicare Part A, Medicare Part B, or other)
Primary care provider (PCP), if one has been selected

Medical Management Program

Medical management models

Our medical management solutions are at the center of our innovative approach to health care benefits. We currently offer clients five core medical management models: Personal Health Solutions (PHS), Personal Health Solutions Plus (PHS+), Health Matters℠ Care Management Basic, Health Matters℠ Care Management Preferred (Care Management Preferred), and Health Matters℠ Care Management Complete (Care Management Complete). All of these models include prospective, concurrent, and retrospective reviews, as well as case management services and 24/7 access to health information and customer service.

Note: *This information may not apply to provider groups when Cigna or an employer group has delegated responsibility for utilization management to another entity. If you participate with Cigna through a delegated arrangement, please continue to follow the delegate's processes. Some employer groups have customized medical management options with requirements that vary from the requirements described in this section.*

Personal Health Solutions (PHS)

- Precertification of coverage is required for all non-obstetric and non-emergent inpatient admissions, including rehabilitation, skilled nursing facilities, hospice, and long term care facilities. Precertification of coverage is also required for all admissions from the emergency department, with notification provided to Cigna within one business day of the admission unless otherwise required by state law.
- Inpatient case management (concurrent stay review) generally begins on the approved MCG length-of-stay plus two days, or as indicated by the diagnosis, for participants still in the inpatient setting.
- Nurses primarily provide telephonic inpatient case management for participants, as well as referrals to ongoing case management post-discharge, if appropriate. In a limited number of facilities, nurses provide inpatient case management on site.

Personal Health Solutions Plus (PHS+), Health Matters – Basic, Health Matters-Complete and Health Matters-Preferred

In addition to the PHS provisions above related to inpatient admissions, precertification of coverage is also required for certain selected outpatient services.

- Inpatient case management (continued stay review) generally begins on the first day of hospitalization, or on the approved MCG length-of-stay minus one day. As with PHS, nurses provide inpatient case management for participants, as well as referrals to ongoing case management post-discharge, if appropriate.

Precertification protocol

Our precertification program helps you determine if your patients' care will be covered under their benefit plan. The precertification process also helps direct participants to various support programs, such as wellness coaching, chronic condition coaching, and case management.

In an effort to support accurate coverage determinations and access to quality care for plan participants, we continually review our precertification process and requirements. Updates include additions and removals based on our standard coverage policy review process, as well as new Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that require precertification. We may make additional changes to the precertification requirements, as needed.

Utilization management – responsibility for precertification

To accomplish these goals, we require that referring (ordering or admitting) physicians request and obtain precertification for in-network services. The rendering facility or provider is responsible for validating that precertification has been obtained for all elective (i.e., non-emergent or non-urgent) services prior to performing the service for patients whose benefit plans require precertification.

Precertification of coverage determinations is based upon the patient's eligibility, the specific terms of the applicable benefit plan, internal or external clinical coverage guidelines, and the patient's particular circumstances.

Failure to obtain precertification may result in an administrative denial of payment. For more information, please see the specific requirements in the following sections.

Utilization management – precertification of inpatient admissions

We require precertification for all planned inpatient non-obstetrical admissions for all of our medical management models.

We review certain procedures to establish medical necessity, confirm that the proposed length of stay is appropriate, and determine if the requested services are covered benefits.

Maternity and obstetric admissions

Maternity and obstetric admissions that result in a length of stay of not more than 48 hours after vaginal deliveries or not more than 96 hours after Cesarean deliveries do not require precertification. These admissions are referred to as "pre-qualified maternity stays." However, please note that precertification *is* required for obstetric admissions that extend beyond 48 hours following vaginal deliveries or 96 hours following Cesarean deliveries.

Emergency services

Precertification is not required for emergency services. However, emergency services that result in an inpatient hospital admission must be reported within one business day of the admission unless dictated otherwise by state law.

The following information is typically required for precertification:

- Participant name and ID number
- Participant date-of-birth

- Diagnosis including ICD-10-CM
- Requesting or referring provider
- Servicing provider, vendor, or facility
- Pertinent medical history and justification for service
- Date of injury (if applicable)
- Anticipated length of stay for inpatient stays
- Date of request
- Additional insurance coverage (if applicable)
- Place of service and level of care (inpatient and outpatient)
- Description and code for procedure, service, or item to be precertified (CPT-4 or HCPCS)

Precertification requirements
You can verify precertification requirements by logging in to the secure Cigna for Health Care Professionals website at (CignaforHCP.com > Precertification Process > Patients > View & Submit Precertifications), or by calling the telephone number on the patient's ID card.

Please note the following:

- Precertification is required at least two days prior to the admission date for all elective, inpatient admissions unless mandated otherwise by applicable federal or state law.
- All urgent and emergent admissions, including observation admissions require notification within one business day of the inpatient admission unless mandated otherwise.
- Precertification is required for all anesthesia and facility charges that are provided for non-covered dental care and for elective admission to other inpatient facilities such as skilled nursing facilities, inpatient hospices, and rehabilitation centers.
- Upon submission of a precertification request, please provide all required information. Failure to provide all necessary information required for the review may result in the denial of certification for an admission, procedure or service. To submit additional information to supplement a previously submitted precertification request, please submit via the original form of transmission.

Utilization management – precertification of outpatient services
With the PHS+, Health Matters-Complete and Health Matters-Preferred models, selected outpatient surgeries, procedures, and services also must be precertified.

Please note that we will deny reimbursement for outpatient services that require precertification if precertification was not requested. This is true regardless of medical necessity, unless the facility or provider can demonstrate upon appeal that the services were performed on an emergency basis or that extenuating circumstances prevented precertification.

Outpatient surgery rates include all post-operative care required within the first 23 hours post-procedure, including recovery room care and observation. Therefore,

precertification of coverage is not required for post-operative care, but is required if a participant needs to be admitted as an inpatient.

All other outpatient services that require precertification, but that are performed without obtaining precertification, will be denied. This does not include services that are performed in an emergency room. In some cases, an appeal may be needed to show that there were extenuating circumstances, or the service was urgent or emergent. If the appeal documents this successfully, then the service will be reviewed clinically for coverage.

Extenuating circumstances

Extenuating circumstances are factors beyond the control of the rendering provider or facility that make it impractical to obtain or validate the existence of a precertification of coverage prior to rendering the service (e.g., natural disaster or incorrect insurance information).

Additionally, emergency and urgent care services that are performed in the emergency room do not require precertification and will be considered at the in-network benefit level.

For emergency or urgent services that were not performed in the emergency room, the provider or facility must submit evidence of why the service or test was required to us within 24 hours (i.e., why the condition required prompt medical attention).

If payment is denied, but the services meet the extenuating circumstances criteria (as outlined below), the provider or facility should submit proof and a copy of the Explanation of Payment (EOP) to the address on the back of the patient's ID card for review.

Evidence of extenuating circumstances

For evidence of extenuating circumstances, the provider or facility must submit appropriate medical records and an explanation of the extraordinary circumstances responsible for the failure to obtain precertification.
For example, in circumstances where the patient submitted the wrong insurance information, the provider or facility should submit documentation that shows the patient submitted the wrong insurance information (e.g., a copy of the patient's insurance card, note in office records, etc.). The denial decision will be upheld if the provider or facility only submits a medical record and not the explanation.

As a reminder, under the terms of your Cigna provider agreement, you cannot bill Cigna plan participants for covered services that are denied due to failure to obtain precertification.

Outpatient precertification list

We have one precertification list for Cigna participants. The list of outpatient services requiring precertification of coverage under the PHS+, Health Matters-Preferred and Health Matters-Complete models is occasionally updated. The most current list of services requiring precertification can be accessed on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Precertification Process > Useful Links > Precertification Policies).

The following is a list of outpatient services that **must be precertified** under standard PHS+, Health Matters-Preferred, Health Matters-Complete, and Health Matters Basic Standard benefit plans, as of January 1, 2020.

• Air ambulance	• Anesthesia and/or facility fees for non-covered dental services
• Back and spine procedures	• Insulin pumps
• Cardioverter-Defibrillator Pulse Generators	• Cochlear implants
• Cosmetic procedures	• Dental implants
• Diagnostic Cardiac Management	• Injectable infused medications/drugs, including oncology drugs
• Elective MRA, MRI, MRS, CT, and PET scans	• Electrical stimulation/ transcutaneous electrical nerve stimulation (TENS)/osteogenesis stimulation
• External prosthetic appliances (some codes)	• Gastric bypass – inpatient or outpatient
• Gene therapy	• Genetic testing
• Home health care	• Home infusion therapy, when provided by a fee-for-service or discount provider
• Implants	• Infertility treatment
• Interventional pain management (e.g., implantable infusion pumps, spinal and peripheral nerve stimulators, spin injections)	• Intensive outpatient programs
• Medical oncology drugs	• Neurostimulators
• Musculoskeletal procedures	• New and emerging technologies
• Non-Routine Psychiatric Outpatient Procedures and Services	• Orthotics
• Orthognathic procedures	• Penile implants
• Partial Hospitalization Programs	• Power-operated vehicles
• Potential experimental, investigational, and/or unproven treatments	• Procedures to treat injury to healthy natural teeth
• Private duty nursing	• Skin and tissue substitutes
• Seat lifts	• Specialty oxygen systems
• Sleep studies	• Special wheelchairs
• Speech-generating devices	• Speech therapy

• Temporomandibular Joint Syndrome (TMJ) procedures	• Therapeutic radiology
• Transgender surgery	• Transplants
• Unlisted procedures	• Varicose vein treatment
• Uvulopalatopharyngoplasty	

General considerations – Precertification: inpatient or outpatient services
Precertification is neither a guarantee of payment nor a guarantee that billed codes will not be considered incidental or mutually exclusive to other billed services. Coverage is subject to the terms of a participant's benefit plan and eligibility on the date of service.

We (or our designees) make coverage determinations in accordance with the timeframes required under applicable law. You must supply all information requested within the timeframes specified for us to make a precertification determination. Failure to provide information within the timeframes requested may result in non-payment.

If a precertification request is approved, a precertification number is assigned. Some situations may require a second precertification number, including:

- Transfer to another facility; or
- Transfer from an acute hospital bed to a rehabilitation, skilled nursing facility, or inpatient hospice bed within the same facility.

Our Coverage Policy Unit is responsible for the development of internal clinical guidelines, as well as for the proper use of externally developed guidelines (e.g., MCG). Our utilization management staff or delegates use these guidelines to assess the medical necessity of a treatment or procedure, determine coverage for an appropriate inpatient length of stay, or make other clinically based coverage decisions.

Coverage for services is reviewed on a case-by-case basis. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the individual's benefit plan document – a group service agreement, evidence of coverage, certificate of coverage, Summary Plan Description (SPD), or similar document.

However, in order to facilitate accurate and consistent coverage determinations, we maintain certain collateral source information and product-specific tools that aid our staff in applying the terms of a benefit plan document to a particular benefit request.

Copies of the clinical coverage guidelines and other resources used in making coverage determinations are available at CignaforHCP.com, or by calling 800.88Cigna (882.4462).

Retrospective precertification of inpatient and outpatient services
Cigna, or our delegate, may consider retrospective precertification requests if received within 15 business days of the date of service for our standard book of business. Outpatient services must meet urgent/emergent or extenuating circumstances criteria to be reviewed. Some business segments may allow additional time. Requests beyond 15 business days will not be accepted. Instead, the provider must appeal the initial denial for failure to secure precertification.

Provider offices are encouraged to supply as much information as possible when requesting a retrospective precertification request so we can perform a thorough review.

Reviewing utilization management and coverage decisions

A Cigna medical director is available to discuss utilization management issues and coverage determinations. This process, referred to as the "peer-to-peer review process," gives you the opportunity to provide additional clinical information.

As a result of this process, a medical director may revise a previous coverage denial decision. However, if a peer-to-peer review does not result in a revised coverage decision, you may still request an appeal through the Cigna appeal process.

Providers can discuss a coverage denial decision with a medical director by initiating a peer-to-peer discussion. You can do this by calling 800.88Cigna (882.4462) or 866.494.2111 for individuals with "G" ID cards.

Please note that we (and our delegated utilization review agents) do not reward the participants involved in the medical necessity based coverage review process for issuing denials of coverage, nor do we provide them with financial incentives to deny coverage of medically necessary and appropriate care.

Specialty pharmacy requirement

When an individual's health plan requires prior authorization, we require the National Drug Code (NDC) number, NDC units, NDC unit qualifier, and Healthcare Common Procedure Coding System (HCPCS) code in three claim scenarios:

- Not otherwise classified HCPCS codes (e.g., J3490, J3590, and J9999)
- HCPCS codes with utilization management controls (e.g., J0725, J1830, and J2941)
- Newly launched HCPCS codes without an average sale price

Pre-notification policy

Pre-notification is required for all hemodialysis, peritoneal dialysis, and home dialysis services for patients whose ID cards include the "Cigna" or "G" identifier. Please pre-notify us two business days prior to the patient's initial assessment or dialysis treatment. To pre-notify us of these services, please call Customer Service at 800.88Cigna (882.4462).

Laboratory tests

This information pertains to all provider types (e.g. physicians or facilities)

Laboratory test procedures must be performed in the physician's or facility's laboratory by that provider/provider's staff. Reimbursement will be made only for covered services that the laboratory is certified to perform through the Clinical Laboratory Improvement Amendments (CLIA) regulations.

Pass-through billing

Please note that services billed as pass-through billing are not reimbursable as covered services. Pass-through billing occurs when an entity bills for a service that is not actually

performed by that billing entity. These tests may not be billed to Cigna or any Cigna affiliate, payer affiliate, payer, or participant.

Inpatient case management (continued stay review)

Under our inpatient case management (continued stay review) program, we (or our designee's nurses or medical directors) review coverage for a patient's hospital stay and help facilitate discharge planning and post-hospitalization follow-up. As part of this, you are required to provide us (or our designee) access to certain information, including:

- Medical records that document a patient's clinical status
- A treatment plan that is consistent with continued inpatient care
- Documentation that a patient's condition cannot be managed safely at another level of care (e.g., skilled nursing facility, outpatient, or home), if applicable
- Discharge planning documentation

Non-authorization of benefits

This information pertains to hospitals and ancillary facilities only

In certain cases, we may not precertify coverage of benefits for hospital admissions or continued hospitalization. Some examples include:

- When a hospital does not provide timely clinical information that substantiates medical necessity
- When there are delays in services that prolong a patients' length of stay. Delays include:
  - The unavailability of an operating or procedure room space
  - Rescheduling surgery or procedures for space-related reasons
  - Inadequate nursing procedure
  - Suboptimal planning, sequencing, or management of medical care or discharge arrangements
  - The failure to obtain necessary ancillary or diagnostic services
- Elective surgeries that are not performed on the day of admission, unless a preoperative day has been precertified

Providers can discuss a coverage denial decision with a medical director by initiating a peer-to-peer discussion. You can do this by calling 800.88Cigna (882.4462) or 866.494.2111 for individuals with "G" ID cards.

Case management

We have many case management programs to serve your patients, including core case management for short-term, complex, and catastrophic cases. We also have specialty case management programs and services, including high risk maternity, oncology, transplant, chronic kidney disease, and neonatal intensive care unit (NICU).

Your participation in, and support of, our case management programs is critical to help meet our shared goal of achieving the best clinical outcomes for your patients. Our case managers are ready and available to support your treatment plan in order to help

patients understand the importance of adherence to treatment plans. Our focus is to help reduce preventable readmissions and to identify potential gaps in care.

Our nurses can support your treatment plan by:

- Reviewing your treatment plan with the patient by telephone to help ensure the patient understands how to use their medications
- Helping you and your patients close identified and confirmed gaps in care by providing information such as using generic prescription drugs instead of brand name drugs and using reminder systems for taking prescription medications and receiving preventive services. They can also provide access to services like smoking cessation, dietary management, depression, or stress management
- Assisting with access to necessary services including skilled nursing, physical therapy, durable medical equipment, chronic condition management programs, and mail order pharmacy (as well as providing information on the approved drug list)

For more information, or to refer a patient to a case management program, please call:

- 800.88Cigna (882.4462) for patients with Cigna ID cards
- 866.494.2111 for patients with "G" ID cards

Core case management

Core case management is for short-term, complex, and catastrophic cases. Our case management programs offer a highly focused, integrated approach that promotes access to evidence-based and cost-effective health care. The complex and catastrophic case management programs are designed to enhance the quality of care and quality of life for participants with severe and complex conditions.

Case managers are experienced nurses who work with you, your patients and their families to help coordinate care and benefits, explore care alternatives, monitor progress, coordinate discharge planning and follow-up, and help ensure that benefits are used effectively. The process typically includes the main components of case identification, case assessment, service plan implementation, service plan evaluation, and case closure.

Case management teams use targeted evidence-based tools to identify and monitor program participants, enhance care coordination, address potential gaps in care, and help participants get the most from their health care plan. While case management of catastrophic cases is considered core case management, case managers who work with these patients have specialized training.

Specialty case management

In addition to our core case management programs, we offer several focused specialty case management programs that can help positively affect an individual's health, while reducing medical costs.

Dedicated nurse case managers with specific expertise and training work collaboratively with you and specialty physician leads to help participants with high-impact conditions like high-risk maternity, neonatal intensive care unit (NICU), oncology, chronic kidney disease, and transplants.

These programs are a vital enhancement to our standard case management programs and are designed to help participants with significant, complex conditions become more active, informed participants in their own care.

These case management programs are available to individuals with Cigna-administered coverage at no additional charge to them or to their employers. For more information, or to refer a patient, please call 800.88Cigna (882.4462) (or 866.494.2111 for participants with “G” ID cards). For transplant referrals, please call 800.668.9682.

Referral guidelines

This information pertains to physicians and other providers only

For certain Cigna plans, primary care providers (PCPs) are required to make patient referrals to specialists in order for:

- Any part of that specialty care to be covered (the customer may otherwise be responsible for full payment), or
- Covered care to be reimbursed at the highest coverage level

PCP and specialist responsibilities

When referrals are required, PCPs are responsible for:

- Providing the patient with a written referral to the specialist
- Noting the referral in the patient's medical record
- Submitting the referral to Cigna for certain plans

Specialists are also responsible for:

- Noting the referral in the patient's medical record
- Communicating with the PCP as appropriate about the diagnosis, treatment, or follow-up care
- Contacting the PCP for a written referral if they do not receive one

Cigna Connect, Cigna SureFit, HMO, and Network plans

PCPs are required to refer participants with Connect, SureFit, HMO, or Network plan coverage to specialists who participate in the network aligned to that plan. Note that Connect and some SureFit plans also require that PCPs submit these referrals to Cigna.

Cigna Point of Service plans

PCPs are encouraged to refer participants with Point of Service (POS) plan coverage to specialists who participate in the network aligned to the plan. This can help ensure their patients receive the highest level of coverage available, and prevent them from incurring unexpected, out-of-pocket costs. However, participants may receive care from participating or non-participating specialists without a referral from their PCP.

How to submit referrals to Cigna (Connect and Cigna SureFit plans)

There are multiple options for PCPs to submit referrals to Cigna:

- Health Care Request and Response (ANSI 278): contact your Electronic Data Interchange (EDI) or Practice Management System vendor
- Phone: 866.494.2111

- Fax: 866.873.8279. You can obtain a referral form on the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Forms Center > Medical Forms).
- Mail: Cigna
  Attn. Precertification and Referral Department, 2nd Floor
  1640 Dallas Parkway
  Plano, TX 75093

File written referral documentation in the patient's record. Referral documentation must include:

- The name of PCP
- The name of specialty care physician that the patient was referred to
- The reason for referral
- Any limitations on referral (if applicable)

To ensure that referrals are documented, we monitor compliance with the referral requirements through the routine medical record review process for PCPs, as well as through random and targeted audits of specialty care physicians' medical records.

When making referrals, please keep in mind that we (or our designees) must authorize coverage for services that require precertification. Additionally, we must authorize services that are performed by a non-participating provider in advance if requesting in-network benefits.

Exceptions for submitting referrals: **state mandates**

Certain states mandate that referrals **not** be required for some specialists or services:

› **Arizona** – OB/GYNs, dentists (pediatric), vision care (pediatric), and chiropractors

› **Colorado** – OB/GYNs, dentists (pediatric), vision care (adult and pediatric), and certified nurse midwives

› **Florida** – Dermatologists for the first 5 visits, OB/GYNs, chiropractors and podiatrists

› **Illinois, North Carolina, Tennessee and Texas** –OB/GYNs, dentists (pediatric), and vision care (pediatric)

› **Missouri** – PCP selection is not required and referrals are encouraged

› **Virginia** – OB/GYNs, physical therapists, and any specialty physicians that treat life threatening, degenerative disabling or cancer diagnosis

› Referrals are not required for the following in any market:

– Lab and radiology**
– Behavioral provider
– Emergency or urgent care

** However, prior authorization or precertification may be needed.

Referral process

This information pertains to physicians and other providers only

When making an in-network referral to a participating specialist, hospital (including emergency services), or ancillary facility for an individual with Cigna-administered coverage, please follow this process:

1. A primary care provider (PCP) typically initiates a patient referral to a Cigna-participating physician during an office visit based upon medical necessity. Approval is subject to participant eligibility and benefits at the time of visit.
2. The physician or other provider who was referred, will examine and treat the patient (as authorized by the PCP), and will document recommendations and treatment.
3. The referral physician or other provider will keep the PCP informed of findings and treatment plan.
4. The referral physician or other provider submits a bill to a Cigna claim service center (see the specialty networks section, if applicable).
5. If the referral physician or other provider determines that the patient needs to see another physician or other provider, the PCP should generate a new referral.
6. The PCP coordinates all other services.
7. A PCP must select a physician or other provider that participates in the Cigna network. If the patient prefers a Cigna participating physician or provider, the PCP may accommodate that preference.

Exceptions to referral process

Provider groups that we have delegated utilization management responsibility to should continue to follow their administrative requirements.

Open Access, Open Access Plus, and PPO

Participants with Open Access, Open Access Plus, and PPO plans do not need a referral to see a specialist.

Obstetrics and gynecology (OB/GYN) care

Although female patients may visit their PCP for an annual well-woman exam, they also may self-refer to a participating OB/GYN for OB/GYN care, as well as to a participating radiologist for a yearly mammogram. However, we do ask that OB/GYN physicians notify us upon diagnosis of pregnancy to initiate the patient's enrollment in our Healthy Babies® prenatal education and support program.

Mental health and substance use disorder program

Mental health and substance use disorder services are generally provided through Cigna Behavioral Health, Inc. However, please verify your patient's coverage online at CignaforHCP.com for participants with Cigna-administered coverage.
You many also verify coverage through your EDI vendor or by contacting Customer Service. Please check the patient's ID card to verify coverage, as some employers have elected other providers to provide these benefits.

Patients that are eligible for behavioral health benefits may call the Customer Service number on their ID card. A mental health coordinator will assess the situation and determine the appropriate service options under the patient's benefit plan. Please note that a referral is not needed for routine outpatient mental health or substance use disorder services.

Vision care

Some participants have direct access to routine vision care with participating vision providers, and therefore do not require referrals. You can verify coverage for these

individuals online at CignaforHCP.com > Patients > Search Patients. You may also verify coverage through your EDI vendor, or by contacting Customer Service at the number on the back of the patient's ID card.

Chiropractic care

Some participants have direct access to routine chiropractic care with participating chiropractors and therefore do not require referrals. You can verify coverage for these individuals online at CignaforHCP.com > Patients > Search Patients. You may also verify coverage through your EDI vendor, or by contacting Customer Service at the number on the back of the patient's ID card.

Medical management delegate performance data

Cigna allows its delegates to collect performance data necessary to assess participant experience and clinical performance, as applicable to delegated utilization management including case management functions. In the event the delegate is unable to collect this data, upon the delegate's request, Cigna will work with the delegate to provide performance data (that is available from Cigna's processes) to assess participant experience and/or clinical performance, as applicable to delegated functions.

Claims and Compensation

Timely and accurate reimbursement is important to you and us. We have a number of customer service and claim centers throughout the country responsible for processing claims. For some participants, a third party, in accordance with Cigna standards may provide claims processing. The customer service telephone number and claim center mailing address are displayed on your patient's ID card. Check the ID card at each visit for the most current information.

Claim submission

You can help improve claim processing accuracy and timeliness by following Cigna guidelines. Be consistent with your demographic information when identifying yourself in claim submissions. If you need to change the way you submit claims, refer to the demographics section of this guide. Using abbreviations or variations of names, or doing business as (DBA) names with combinations of your licensure numbers, national provider identifiers (NPIs), and tax identification numbers not listed in the your agreement can delay or result in incorrect claim payments. Notify Cigna in advance of changes to your information.

Cigna requires all claims to be submitted for processing, including but not limited to, claims paid in full at the time of service and non-covered services. This information is used for other program outreach and reporting purposes.

We strongly encourage you to submit your claims electronically.

Electronic claim submission

Submitting claims electronically can help you save time, money, and improve claim processing accuracy.

Submitting claims electronically to Cigna can help you to:

- Send primary and secondary coordination of benefits (COB) claims quickly, reduce paperwork, and eliminate printing and mailing expenses
- Decrease the chance of transcription errors or missing data
- Track claims received electronically, which are automatically archived before processing
- Eliminate the need to submit claims to multiple locations
- Save time on resubmissions – incomplete or invalid claims can be reviewed and corrected online
- Receive confirmation that Cigna accepted your claim, or a claim rejection notification.

Cigna payer IDs for submitting electronic claims

Payer ID	Claim type
62308*	Medical, behavioral (including employee assistance program), dental, and Cigna-HealthSpring Arizona Medicare

* Both primary and secondary (COB) claims can be submitted electronically to Cigna.

You don't have to submit Medicare Part A and B coordination of benefits agreement (COBA) claims to Cigna, as the Medicare explanation of benefit (EOB) or electronic remittance advice (ERA) will show that those claims submitted to Medicare are forwarded to Cigna as the secondary payer.

Paper claim submission
We strongly encourage you to submit claims electronically to save time and money. However, if you need to file a paper claim, use one of these claim forms:

UB04 form for hospital charges	CMS-1500 form for all other charges

In instances where you must submit a paper claim, Cigna will scan, sort, and store the claim electronically to reduce manual keying errors and improve response time. Follow these guidelines when completing and submitting paper claims:

- If using a super bill or form other than a UB04 or CMS-1500, the form must have the same information fields listed in the "Definition of a Complete Claim" section below.
- Include your national provider identifier (NPI) on the claim
- Make sure all appropriate claim form fields are completed; use black ink when handwriting information
- Refer to the patient's Cigna ID card for the correct claim submission address
- Include the patient's Cigna ID number on all claim attachments and correspondence

If submitting a replacement or corrected claim, please do not stamp "Corrected Claim" on the claim form. Corrected claims should follow the NUBC Guidelines, which are listed below:

- HCFA: Field 22 should include a '7' or '8' to indicate a replacement or voided claim.
- UB: The Claim Frequency Type Code should be submitted with a '7' or '8' in Form Locator 4, as well, as the tracking number.

Definition of a complete claim
Cigna defines a complete claim as including the following information:

The claim at a minimum must include:	
Patient name and address	Location of service
Patient date of birth and gender	Patient relationship to subscriber
Subscriber name and address	Subscriber ID number and date of birth
Subscriber group number	Patient/subscriber authorized signature
Other insurance information	Name of referring physician
Referral/approval number	Admit/discharge date and time
Admitting/attending physician	Other or secondary insurance information
Diagnosis codes (ICD, DRG)	Date of current illness

First date of same or similar illness	Date of service
Provider name, address and telephone number	Taxpayer Identification Number (TIN) and National Provider Identifier (NPI)
Description of procedure(s)	Billed charge or amount for each procedure
Cigna Provider ID Number (all digits and suffix)	Standard code sets (CPT4, HCPCS, NDC, NDC units, HCPC units, or Revenue Code to HCPCS combinations as required by CMS/NUBC)
Note: Any state law, HIPAA transaction, and code set requirements, or plan-specific language inconsistent with the Cigna Standard Administrative Guidelines and Program Requirements will supersede these guidelines in the event of a conflict.	

Present on Admission (POA) Indicator

Cigna requires the POA indicator to be present for all diagnosis codes submitted on the inpatient claim form. Cigna reserves the right to return any inpatient claim without a POA indicator. For additional information, refer to the Hospital Acquired Conditions Reimbursement Policy located on the secure Cigna for Health Care Professional website (CignaforHCP.com) > Resources > Clinical Reimbursement Policies and Payment Policies > Modifiers and Reimbursement Policies).

Supplemental claim information

Sometimes it is necessary to include additional information to support a claim or make a benefit determination. Supplemental documentation should be included or sent as soon as possible after requested to avoid delays in claim processing.

Requests for supplemental claim information are sent to the address we have on file for you in our demographic databases, which could potentially be a lock box for claim payments. Please make sure we have the most current and correct mailing address for you in our database so you receive supplemental claim information, requests, and other correspondence from us in a timely manner.

In the table below is a sample of claim categories that require supplemental information. A complete, up-to-date listing is available at CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Claim Policies and Procedures > Clean Claim Requirements. (The requirement to provide supplemental claim information is subject to applicable law and, in the event of a conflict, applicable law will control.)

Claim category	Supplemental attachment
Air ambulance	Narrative/transport notes
Anesthesia	Time must be specified
Billing Appropriateness	Itemized bill/clinical records or notes

Claim category	Supplemental attachment
Coordination of Benefits (COB)	Cigna payer ID 62308 is able to receive COB claims electronically. Please contact your vendor for information on how to submit COB claims electronically. For paper claims, provide a copy of the primary carrier's explanation of payment (EOP) when Cigna is secondary.
Cosmetic or Potentially Cosmetic Procedures	• Operative report • Office notes and treatment plan • History and physical • Photos (if available) • Height/weight • Operative report and treatment results (if already performed) • (For Blepharoplasty – visual field testing results)
DRG Clinical Review	Clinical records or notes
Drugs--Injectable	Healthcare Common Procedure Coding System (HCPCS) codes or National Drug Codes (NDCs) When an individual's health plan requires prior authorization, Cigna requires the NDC number, NDC units, NDC unit qualifier, and HCPCS code in three claim scenarios: • Not otherwise classified HCPCS codes (e.g., J3490, J3590, and J9999) • HCPCS codes with utilization management controls (e.g., J0725, J1830, and J2941) • Newly launched HCPCS codes without an average sale price
Experimental, Investigational or Unproven Procedures	Operative or physician notes or other clinical information
High Dollar Claims	Itemized bill
Home Health Care	• Office notes and treatment plan • All visit notes, complete history and physical • Infusion drug report, if applicable

Claim category	Supplemental attachment
Modifiers: • 22 – Increased procedural services • 25 – Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service • 59 – Distinct procedural service • 62 – Two surgeons • 66 – Surgical team • Other modifiers may require additional information	Operative, office or physician notes or other clinical information (A select few NCCI modifier 25 and 59 code pairs require documentation with the initial professional claim (CMS-1500) submission. Claims should continue to be submitted electronically to Cigna, even if supporting documentation is required. Indicate in the PWK (Claim Supplemental Information) segment of Loop 2300 of the electronic claim that the documentation will be sent through another channel. Refer to the Modifier 25 and 59 Policies and code lists available on the secure Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Clinical Reimbursement Policies and Payment Policies > Modifiers and Reimbursement Policies) for more information.
Morbid Obesity	• Complete history and physical • Proposed treatment plan, including any surgical procedures • Measures tried previously and patient's response
Pre-determinations	• Office notes and treatment plan • Complete history and physical • Photographs, if applicable • Pertinent Diagnostic Study Results
Provider Stop Loss (Facility only)	Itemization by date of service and revenue code may be needed depending on the type of stop loss provision
Unexpected Place of Service (example: office services performed in an ASC, etc.)	Operative or physician notes or other clinical information

Claim category	Supplemental attachment
Unlisted CPT or HCPCS codes (example: CPT codes ending in “99”, such as CPT Code 64999 – Unlisted procedure, nervous system), also includes unidentifiable services	• A clear description of the service, device, or procedure provided, if the unlisted code is submitted for a drug, provide the name, dosage, NDC number, NDC units, HCPC units, and medical necessity for the drug. If the unlisted code is for a surgical service, provide the operative report. • Reference to whether the service, device or procedure was provided separately from any other service, device or procedure rendered • Information to establish medical necessity for the service, device or procedure • Radiology – detailed description of the approved radiology procedure • Laboratory/Pathology – Laboratory or Pathology report pointing out the specific test used

Claim filing deadline

Claims should be filed as soon as possible to promote prompt payment. Cigna will only consider claims submitted within 90 days of the date of service, or as otherwise defined in your provider agreement and the exceptions noted below.

For services rendered on consecutive days, such as for a hospital confinement, the filing limit will be counted from the last date of service.

The following are current exceptions to the 90-day time limit:

- Applicable state law provides for a longer timely filing limit in which case that time limit will apply
- Coordination of benefits (90-day filing limit is applied based on the primary carrier’s processing date as stated on an explanation of benefit or payment)
- Medicare (90-day filing limit is applied based on the primary carrier’s processing date as stated on an explanation of benefit or payment)
- Medicare secondary payer (three years)
  Medicaid (three years)
- Resubmission of a claim originally filed in a timely manner, returned with new or additional information as requested by Cigna (90-day filing limit is reset to the date of the Cigna request for more information)
- Services provided to participants through arrangements with third-party vendors (filing limit is applied based on third-party requirements, which may be more or less than 90 days)
- Extenuating circumstances (e.g., catastrophic events)

Claim inquiry and follow-up

Providers can inquire about claim status using electronic data interchange claim status inquiry (276/277) through your EDI vendor; our website, CignaforHCP.com; interactive voice response (IVR) systems; or by calling Cigna customer service number on the patient's ID card or on the explanation of payment. When contacting Cigna, have the following information available:

Provider name	National Provider ID number
Taxpayer Identification Number (TIN)	Patient name
Patient ID	Subscriber name
Date of service	Description of service
Amount of claim	Date claim was submitted

Our website is available to providers for verifying claim status by logging in to the secure Cigna for Health Care Professionals website (CignaforHCP.com).

To learn more about connecting electronically with Cigna visit Cigna.com/EDIvendors.

The claim inquiry and follow-up options listed above allow providers to access details of processed claim information 24 hours a day, seven days a week.

When inquiring on the status of a claim on the website, or through your EDI vendor's claim status inquiry (276/277), you will receive:

- Status of each claim using the standard HIPAA claim status and claims status category codes
- Cigna claim number
- Total charge and paid amounts
- Claim processed date
- Payment date, method (check or electronic funds transfer) and check number
- Claim status history available for two years

By calling the number on the participant's ID card, you can either access the automated IVR system for claim status 24 hours a day, seven days a week, or speak to a Customer Service Representative during normal business hours.

Claim payment policies and procedures

Claims from participating providers are subject to our claim payment policies and procedures. These policies are the guidelines adopted by us for calculating payment of claims and include our standard claim code auditing methodology, review of charges to service provided and procedures for claims adjudication. This guide contains information about some of our payment policies. Please review the information online or call the number listed on the participant's ID card for additional questions or information.

Standard claim coding/bundling methodology

If you have questions concerning our standard claim coding, bundling methodology, payment policies, or about how specific types of billing codes will be processed, you can

visit the secure Cigna for Health Care Professionals website at (CignaforHCP.com > Resources > Policies and Procedures > Claim Editing Policies and Procedures).

Standard site of service
On January 1, 2017, Cigna began transitioning to the industry-standard CMS Site of Service designations for calculating reimbursement. Reimbursement for certain covered services that are performed by a physician in a location other than the physician's office will be calculated based on the Facility Relative Value Unit (RVU) rather than the Non-Facility (office) RVU. For covered services performed in the physician office, reimbursement will be calculated based on the Non-Facility (office) RVU.
There are certain services/codes that use the Site of Service designation for reimbursement. Site of Service designations are subject to change. Cigna will periodically update the changes in accordance with its own update process, the timing of which may not be in accordance with CMS' release of the change.

Assistant-at-surgery modifiers

This information pertains to physicians and other providers

Assistant-at-surgery (MD or non-MD) services are reported by appending one of the modifiers below to the appropriate CPT/HCPCS procedure code. Allowed amounts are based upon the participant's benefit plan and your contractual agreement with us.

Please note that not all Cigna insured or administered benefit plans cover non-physician assistants at surgery. When required, another participating physician should be used as an assistant-at-surgery to help the patient maximize his or her benefits.

Assistant Surgeons (modifiers 80, 81, 82) and Assistants-at-Surgery (modifier AS) are processed per CMS National Physician Fee Schedule designations to Allow, or Not Allow. CMS Assistant Surgeon /Assistant-at-Surgery designations of "2" are allowed without documentation.

Cigna requires supporting documentation to be submitted with the initial claim in order to be considered for payment if CMS assigns the CPT or HCPCS code a '0' designation (may be payable with documentation) for Assistant Surgeons or Assistants-at-Surgery.

For additional information, please refer to the "Modifiers 62, 66, 80, 81, 82 and AS" Reimbursement Policy and Assistant Surgeon Code Listing on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Policies and Procedures > Modifiers and Reimbursement Policies).

Modifier	Definition	Reimbursement policy *
80	Assistant Surgeon	Physician Assistant-at-Surgery: 16% of the allowed amount based on contracted rate or usual and customary (U&C). An Assistant Surgeon must actively assist the Primary Surgeon through an entire operative procedure.

Modifier	Definition	Reimbursement policy *
81	Minimum Assistant Surgeon	Physician Assistant-at-Surgery: 13% of the allowed amount based on the contracted rate or usual and customary U&C. An Assistant Surgeon must actively assist the Primary Surgeon through an entire operative procedure.
82	Assistant Surgeon (when qualified resident surgeon not available)	Physician Assistant-at-Surgery: 16% of the allowed amount based on contracted rate or usual and customary U&C. An Assistant Surgeon must actively assist the Primary Surgeon through an entire operative procedure.
AS	Physician Assistant, Nurse Practitioner, Registered Nurse First Assistant, Advanced Practice Registered Nurse/Advanced Practice Nurse, or Clinical Nurse Specialist services for assistant at surgery	Non-Physician Assistant-at-Surgery: 13.6% of the allowed amount based on contracted rate or usual and customary U&C. The Assistant-at-Surgery must actively assist the Primary Surgeon through an entire operative procedure. Note: not all benefit plans cover non-physician assistants at surgery.

***Note**: All covered services are subject to our multiple procedure policy and the provider agreement, as well as our other standard claim coding methodologies (e.g., ClaimsXten®, Modifier Policy).

Multiple surgery policy

Multiple surgeries or medical procedures (modifier 51) are separate procedures that are performed by a single physician, on the same patient, on the same day (or at the same session) for which separate payment may be allowed. This policy does not apply to procedures that are deemed modifier 51 exempt or to add-on codes as defined by the American Medical Association. If appended correctly, reimbursement for modifier 51 is generally 100 percent of the allowed amount for the primary procedure and 50 percent of the allowed amount for secondary procedure.

Bilateral surgeries (modifier 50) are bilateral procedures that are performed at the same operative session. If appended correctly, modifier 50 is applicable only to services or procedures that are performed on identical anatomical sites, aspects, or organs. Modifier 50 does not apply to codes that are inherently bilateral by definition; reimbursement is 100 percent of the allowed amount for the first procedure and 50 percent of the allowed amount for the second procedure.

Tips
• Assistant surgeon, co-surgeon and team surgeon fees are subject to the multiple procedure policy

Tips
• Participating physicians cannot balance bill participants for charges in excess of Cigna allowable amounts
• In some cases, an office visit is not separately reimbursable from the surgical code so the office visit copayment does not apply
• This policy may not apply to facility charges. The administration of multiple surgical reductions will be determined by the facility contract.

Immunization policy

This information pertains to physicians and other providers only

Routine immunizations are covered as medically necessary when **both** of the following criteria are met:

- They are used in accordance with an FDA-licensed indication
- They are used in accordance with an affirmative recommendation by the CDC's Advisory Committee on Immunization Practices (ACIP)

Routine disease prevention vaccines are covered when noted in the provisional affirmative recommendations by the Advisory Committee on Immunization Practice (ACIP), until the recommendations are officially published in the Morbidity and Mortality Weekly Report (MMWR).

Global Maternity Reimbursement Policy

We have created a Global Maternity Reimbursement Policy that outlines our standards for reimbursement of global maternity services.

To view the complete policy, as well as our other reimbursement policies, log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Modifiers and Reimbursement Policies), or call 800.88Cigna (882.4462). If you are not currently registered for the website, go to CignaforHCP.com and click on **"**Register Now**."**

Please note that this policy has applied to claims processed since August 1, 2010.

ClaimsXten

We use ClaimsXten®, a market-leading, rules-based software application, to help expedite and improve the accuracy of medical and behavioral claims submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 claim form and for certain claims submitted on a UB04 claim form. ClaimsXten evaluates claims for adherence to Cigna coverage and reimbursement policies, benefit plans, and industry-standard coding practices based mainly on Centers for Medicare & Medicaid Services (CMS) and American Medical Association (AMA) guidelines.

ClaimsXten uses rules-based logic to:

- Assess if codes billed on a CMS 1500 or UB04 claim form, containing Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) service codes contain coding irregularities, conflicts, or errors;
- Recommend CPT and HCPCS procedure code combinations;
- Implement our coding guidelines, Coverage Policies, and Reimbursement Policies;
- Put into practice the Centers for Medicare and Medicaid Services (CMS) coding modifier guidelines along with National Correct Coding Initiative (NCCI) Column1/Column2 edits.

This code review software is updated throughout the year to stay current with procedural coding and with changes in the medical field. For each update, we review the software's edits to ensure consistency with our policies.

A more detailed summary of ClaimsXten and knowledge base update information is available on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Claim Editing Policies and Procedures).

Providers registered with the secure Cigna for Health Care Professionals website (CignaforHCP.com) may access ClaimsXten Clear Claim Connection™ and enter CPT or HCPCS procedure codes, and immediately view the audit results and Clinical Edit Clarifications. You may connect to ClaimsXten Clear Claim Connection by logging into the Cigna for Health Care Professional website (CignaforHCP.com > Claims > View Claim Coding Edits). To learn more about ClaimsXten Clear Claim Connection, click on the frequently asked questions under the Useful links drop down menu.

Participant liability collection limitations

Copayments: Copayment is a fixed dollar amount that a participant pays per service. Copayment amounts are printed on the Cigna ID card. Collect the applicable copayment amounts on the ID card at the time of service.

Coinsurance and deductibles: For participants with plans that have deductibles or require participants to pay a percentage of the covered charges (coinsurance) after satisfying any deductible amount, submit claims to Cigna or its designee and receive an explanation of payment (EOP) indicating the participants' responsibility before billing patients. Coinsurance and deductibles should not be collected at the time of service unless you have accessed the Cigna Cost of Care Estimator® to obtain an estimate of the deductible and coinsurance obligations of the plan participant, and provided a copy of the estimate to the participant at the time of service.

Many Cigna Choice Fund plan participants have automatic claim forwarding (ACF) enabled so the deductible and coinsurance amounts they owe are paid directly out of their health care account(s). After claim processing, if funds are available, Cigna automatically sends payment to you on behalf of the Cigna Choice Fund participant, usually along with Cigna's portion of the payment. ACF is currently active on the majority of our Choice Fund plan participants.

The Cigna Cost of Care Estimator can inform you and your patients that participate in Cigna medical or behavioral plans of their estimated financial responsibility for services

based on their specific Cigna insured or administered plan. The Estimator is available for all plan participants in Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Open Access Plus (OAP) and Open Access Plus In-Network (OAPIN) plans, Managed care plans (HMO, Network EPP, HMO Access, Network Open Access, HMO POS – Flex, Network POS – DPP, HMO POS Open Access, Network POS Open Access, Open Access Plus (OAP) Open Access Plus In-Network (OAPIN) and LocalPlus), Choice Fund plans, plans for participants with "G" ID cards, and Behavioral plans.

You can access the tool by logging in to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Patients > Search for a Patient > Select a Patient > Estimate Costs).

For additional information about the Estimator log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Medical Resources > Doing Business with Cigna > Cigna Cost of Care Estimator®), or to learn how to use the Estimator, access the Cigna Cost of Care Estimator eCourse in Resources > eCourses.

Fee forgiving/waiver of copayment/coinsurance or deductible: Most benefit plans insured or administered by Cigna exclude from the participant's coverage those charges for which the participant is not obligated to pay. Therefore, if a plan participant is not obligated to pay a charge, any claim for reimbursement for any part of that charge under such a contract or benefit plan is generally not covered. It is Cigna's view that "fee-forgiving" on any particular claim, or any portion thereof, could constitute fraud and may subject a provider to civil and criminal liability.

Denied payment and participant non-liability

You cannot bill participants for covered services or services for which payment was denied due to your failure to comply with your provider agreement or these Program Requirements/ Administrative Guidelines, including Cigna utilization management requirements and timely filing requirements.

Coordination of benefits (COB)

Cigna participants may be covered by more than one health benefit plan. In some cases, payment may be the primary responsibility of other payers. Billing multiple health benefit plans to obtain payment is called coordination of benefits (COB). You should assist Cigna to maximize recoveries under COB and bill services to the responsible primary plan. After receiving a payment or denial notice from the primary plan, you should submit the COB claim electronically to Cigna. However, if you submit COB claims on paper, then a copy of the primary payer explanation of payment is required.
Cigna payer ID 62308 is able to receive COB claims electronically; please contact your vendor for information on how to submit these claims. For more information about electronic claims, go to the Claim Submission section of this guide.

Cigna as primary payer

When the Cigna plan is primary payer, payment is made in accordance with your agreement with Cigna without regard to the secondary plan. After receiving payment from Cigna, submit the COB claim to the secondary plan.

Cigna as secondary payer

When the Cigna plan is secondary payer, first submit the claim to the primary plan. After receiving a payment or denial notice from the primary plan, submit the claim to Cigna, along with a copy of the primary plan EOP. Paper copies are not required if you submit HIPAA-compliant COB content electronically through an EDI claims submission.
Cigna participates in Medicare COBA (Coordination of Benefits Agreement), also known as Medicare Crossover, for individuals whose coverage is made available through Medicare Parts A and B. This eliminates the need for you to submit Medicare COB claims to Cigna. The Medicare explanation of benefit (EOB) or Electronic Remittance Advice (ERA) will show that those claims were forwarded to Cigna as the secondary payer.

Cigna's payment as secondary payer, when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under your Cigna provider agreement, and is subject to the terms and conditions of the participant's health benefit plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Cigna, when added to the amount payable from other sources, which is less than 100 percent of your payment for Covered Services under your Cigna provider agreement.

When Medicare is the primary payer and the Cigna administered plan is the secondary payer, applicable Medicare billing rules (including Medicare COB rules) will apply to your reimbursement. The financial responsibility of the Cigna-administered plan as a secondary payer under Medicare COB rules is limited to the participant's financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the participant liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitutes payment in full, and you are prohibited from collecting any monies in excess of this amount.

Order of benefit determination

Cigna follows the National Association of Insurance Commissioners (NAIC) guidelines about the industry standard of order of benefit determination subject to applicable law and the terms of the benefit plan.

Determining primacy on a participant/spouse

The plan that covers a person as an employee, subscriber, or retiree is always considered the primary payer over a plan that covers the person as a spouse or dependent. If a Cigna subscriber has two employers and has group health insurance coverage through both, the plan for the subscriber who has worked longer for the company is considered primary.

If a person has coverage under a state or federal continuation plan and is covered under another group health insurance plan, the plan covering the person as an employee, subscriber, or retiree (or as that person’s dependent) is primary and the continuation coverage is secondary.

Determining primacy on a dependent child

Dependent children of parents who are married and living together follow the “birthday rule.” The plan of the parent whose birthday falls earlier in the calendar year is primary to the plan of the parent whose birthday falls later in the year. Only the month and day of birth are relevant; birth year is not taken into consideration. If both parents have the same birthday, the parent with the plan that has been in effect longer is primary.

Dependent children of parents who are divorced separated, or not living together follow the “custodial rule.” If a court decree states that one of the parents is responsible for the dependent child’s health care coverage, that parent’s plan is primary, followed by the plan of the other parent. If a court decree awards joint custody without specifying which parent is liable for providing health insurance coverage, the birthday rule is followed

If there is no court decree allocating responsibility for the dependent’s health coverage, the order of benefit determination under the custodial rule is as follows:

1. The plan of the custodial parent
2. The plan of the custodial parent’s spouse, if applicable
3. The plan of the non-custodial parent
4. The plan of the non-custodial parent’s spouse, if applicable

Determining primacy with Medicare

For Medicare beneficiaries, federal law or regulation determines the order of benefit determination, which may differ from the rules described above. The group health plan that covers Medicare beneficiaries, age 65 or older, through active employment (theirs or that of their spouse), and where the employer has 20 or more employees is the primary payer.

The group health plan is primary for Medicare beneficiaries who have end-stage renal disease (ESRD) during the first 30 months of their Medicare eligibility.

Workers’ compensation

Providers must submit a potential workers’ compensation claim to the applicable workers’ compensation carrier for review before submitting the claim to us. If the workers’ compensation carrier denies the claim, a copy of the denial must be included with the claim submission to us. If the workers’ compensation denial is not received with the claim, payment for services will be denied unless state law specifically prohibits a denial on these grounds.

Part of the post-review process may include a Cigna vendor contacting the patient for information about the case. If it is determined that we have made a medical payment on a valid workers’ compensation case, we will require a full refund. The Cigna vendor will provide information about that process. In this case, you should then resubmit the claim to the workers’ compensation carrier responsible for payment.

Subrogation and reimbursement requirements

Subrogation may apply if a patient is injured in an accident of any type, and someone else is responsible for the injury. If you treat a patient with a subrogation claim, your contract, as well as these Administrative Guidelines and Program Requirements, will

apply to the same extent that they apply to any other participant. Appropriate authorizations must be obtained to help ensure payment. Additionally, please note that claims should be submitted to us.

Other billing guidelines

This information pertains to hospitals and ancillary facilities only

Emergency department

The emergency department copayment provision will not apply when a participant is admitted directly from, or within 24-hours of, a related emergency department visit.

Pre-admission and pre-ambulatory testing

Facility claims for pre-admission or pre-ambulatory testing and procedures completed within three days of an elective admission, ambulatory surgery, or diagnostic procedure should be submitted with the claim for the corresponding admission or procedure. These services will be considered and processed as part of the inpatient claim.

Hospital interim billing

When submitting interim billing, hospitals should ensure the coding reflected in the claim is for an interim status bill and the correct bill type is being used. We recommend interim billings be submitted for a minimum of 30 days of service.

Overpayment recovery

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

Cigna
Attn: COR Unit PO Box 188012 Chattanooga, TN 37422
For patients with "G" ID cards
Cigna Attn: Mail Processing Refunds PO Box 188061 Chattanooga, TN 37422 - 8061

Cigna contracts with several vendors to administer the recovery of overpayments. You will be advised when an overpayment has been identified and will be expected to promptly refund any overpaid amount. Our standard recovery method is by refund check. Failure to comply with recovery efforts may result in Cigna initiating the dispute resolution process set forth in your participating agreement. We reserve the right to reduce future reimbursement amounts to recover previous overpayments subject to all statutory and contractual requirements.

Explanation of payment

The Cigna explanation of payment (EOP) itemizes the services processed or considered for payment. We use a standard format for payment explanations, combining the check and claim detail information. The information necessary to reconcile a patient's account with the Cigna payment is provided in a single document. This consolidated format is called the "Check/EOP."

You must be a registered user of our website to access this information. Register by going to CignaforHCP.com and clicking **"**Register Now**."**

Explanation of benefits and explanation of payment

An explanation of benefits (EOB) or explanation of payment (EOP) accompanies all claims payments. The EOB and EOP itemize payment information such as copayments, deductibles, patient responsibility amounts, contracted discounts, payment amounts, and date(s) of service. The payment will be attached at the bottom of the EOB/EOP.

Electronic funds transfer and electronic remittance advice

Cigna offers electronic funds transfer (EFT) and electronic remittance advice (ERA). By enrolling in EFT and ERA together, you can access your funds and complete your accounts receivable posting faster.

EFT is Cigna's standard payment method and you must enroll. EFT is our standard payment method for provider reimbursement.

EFT is a secure, direct deposit into your bank account. It is a proven method for securely receiving your claim fee-for-service and capitated payments.

Reimbursement payments are available the same day the direct deposit is electronically transferred to your bank account. Access a calendar for payment dates by visiting CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Reimbursement > Electronic Funds Transfer.

What are the benefits of EFT?

- Eliminate paper check mail delivery and handling.
- Access funds on the same day of the deposit.
- Increase efficiency and improve cash flow.
- Easily reconcile payments using a single remittance tracking number
- View a separate remittance report online for each deposit, which shows the:
  - Deposit transaction
  - Details about the claims processed
  - Payments included in that fund transfer
- To view remittance reports for each deposit on the Cigna for Health Care Professionals website (CignaforHCP.com):
  - If you are already registered for the website and have access to claims status inquiry, you automatically have access to online remittance reports.

- Primary Administrators: If you have staff that need access to online remittance reports, log in to CignaforHCP.com > Working With Cigna > Assign Access > Modify Existing Users/Add New Users.
- If you are not yet registered for the website, visit CignaforHCP.com and click "Register Now." Once you complete the registration information and it has been validated, you can access your remittance reports online. For step-by-step registration directions, go to CignaforHCP.com and click "Learn How to Register and Log In."

To access your remittance reports, log in to the Cigna for Health Care Professionals website (CignaforHCP.com > Remittance Reports).

- The remittance report shows the deposit transaction, details the claims processed and payments included in that fund transfer.
- For step-by-step instructions how access your remittance reports, go to CignaforHCP.com > Resources > eCourses > Electronic Funds Transfer and Online Remittance Reports

Payment bulking options
Choose between two options to receive your payments:

- Taxpayer Identification Number (TIN) and payment address - By electing TIN bulking, all claims will be grouped into a single payment based on TIN and payment address, or
- National Provider Identifier (NPI) - By electing NPI bulking, all claims will be grouped into a single payment for each "Billing Provider" NPI from the submitted claim
  - The ERA or remittance report will be bulked by TIN or NPI, depending on your payment bulking preference with your EDI vendor
  - You can elect a separate bank account for each "Billing Provider" NPI

Enrolling is easy!

If you are not enrolled for Cigna EFT payments, you must enroll for EFT by one of the methods below.

Enroll in EFT directly with Cigna by logging in to https://cignaforhcp.com >Working with Cigna > Enroll in Electronic Funds Transfer (EFT).
Enroll in EFT and manage EFT accounts with multiple payers, including Cigna, using the Council for Affordable Quality Healthcare® (CAQH) EnrollHub at https://solutions.caqh.org.

Two options to enroll in EFT

- Enroll in EFT and manage EFT accounts with multiple payers, including Cigna, using the Council for Affordable Quality Health Care (CAQH) website: https://solutions.CAQH.org
- Enroll in EFT directly with Cigna by logging in to CignaforHCP.com > Working with Cigna > Electronic Funds Transfer > 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:

    - If the pre-note is not returned to Cigna, you begin receiving EFT on your next payment cycle
    - 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

EFT enrollment guidelines:

- For savings account deposits, verify that your bank will support EFT.
- The enrollment process typically takes four to six weeks.
- If you use more than one Taxpayer Identification Number (TIN), you must complete a separate enrollment for each TIN.
- To have your payments bulked or grouped based on your Billing National Provider Identifier (NPI) from the submitted claim, visit CignaforHCP.com > Working With Cigna > Manage EFT Settings and update your payment bulking preferences.
- If your TIN, NPI, 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.
- To check the status of your EFT enrollment, visit CignaforHCP.com > Working With Cigna > Manage EFT Settings > view Enrollment/Update Status or email providerdirectdeposit@cigna.com and include your TIN in the message.

For step-by-step instructions how enroll in EFT, go to CignaforHCP.com > Resources > eCourses > Electronic Funds Transfer and Online Remittance Reports.

To help reduce your payment cycle Cigna also offers ERA, or the 835. ERA is the HIPAA-compliant detailed explanation of how a submitted health care claim was processed. The ERA may be automatically loaded into your accounts receivable system, which can help:

- Reduce costs and save time
- Reduce posting errors
- Shorten the payment cycle

Cigna provides the information needed to reconcile your payments on the ERA:

- The patient account number you submitted on the claim
- The charge amount, paid amount and patient responsibility for the claim
- The charge amount and paid amount for each service line, except for claims that may be paid at a claim level (e.g., DRG claims)
- The amount and explanation of adjustments between the charge amount and the paid amount
- The allowed amount for each service line
- Adjustments not related to a specific claim (for example, late payment interest or refund acknowledgments)
- The Billing NPI submitted on your claim(s) is included in the Provider Summary (TS3) field to help you easily reconcile your payment

To enroll in ERA

- Notify your EDI vendor that you would like to enroll for Cigna ERA.
- Provide enrollment information as instructed by your EDI vendor (if you use more than one TIN, complete separate enrollment information for each TIN).
- Your EDI vendor will send the completed enrollment information to Cigna for processing; Cigna will finalize your registration within 10 business days of receiving it.
- You may begin receiving ERAs on your next payment cycle.

For information about our EDI vendors and the transactions they support, visit Cigna.com/EDI vendors.

Posting payments and adjustments

In addition to posting applicable payments, you are required to make contractual adjustments to reconcile a patient's account based upon the Cigna contractual or negotiated rate, and as noted on the EOP. Contractual adjustments are reflected on the EOP, ERA or other Cigna remittance or payment statement.

Applicable rate

This information pertains to hospitals and ancillary facilities only

The rates detailed in your provider participation agreement extend to services performed on a Cigna participant, including services covered under the participant's in-network out-of-network benefits. This is true whether it is the Payer or the participant who is financially responsible for payment.

Rates and changes to coverage

This information pertains to hospitals and ancillary facilities only

If a participant with Cigna-administered coverage is an inpatient when a new contracted rate becomes effective, or when the participant's benefit plan changes to a different type of plan (e.g., OAP to HMO, HMO to PPO):

- The hospital's reimbursement for covered services during the inpatient stay will be based upon the rates in effect on the day the patient was admitted to the hospital.

If a participant with Cigna-administered coverage is an inpatient when their coverage status changes:

- The hospital's reimbursement for covered services will be prorated based on the total number of days of the entire length of stay that the patient had Cigna coverage.

Claim quality and cost-effectiveness programs

We manage claims and perform reviews through various quality and cost-focused programs. These programs continue to provide quality results that can help improve both cost-effectiveness and our customers' experience.

Clinical Claim Review Program

The Clinical Claim Review Program evaluates claims for accuracy and appropriateness before a benefit payment determination is made. As part of this program, an experienced

team of professionals, including nurses and physicians, reviews billing and coding to confirm accurate reporting, examines submitted documentation, reviews submitted claims against applicable coverage, payment and reimbursement policies, and verifies coverage for services under the terms of the participant's benefit plan.

Prepayment Review Program
The Prepayment Review Program works in harmony with other programs to enhance claim processing accuracy. The Prepay team's goal is to better manage and finalize claims on a pre-payment basis, which is accomplished by identifying claims that require additional review beyond standard or automatic processing in the claim systems. This non-standard handling permits the team to work claims individually and help ensure correct payment.

Postpayment Review Program
The Postpayment Review Program is responsible for analyzing claims after they have been paid. Nurse and physician reviewers compare a facility's itemized bill and invoices to the events, services, and supplies reported in the patient's medical record. This team also verifies the codes submitted on the claim meet Cigna's reimbursement policies and accurately represent documented services.

Resolving Payment Questions

You can take these steps prior to providing non-emergency treatment or services to a Cigna participant as well as prior to submitting the claim for reimbursement to help avoid unnecessary claim processing delays or denials and minimize the need to pursue the dispute resolution process.

Prior to providing services:

- Log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com).
  - Verify benefits for the participant
  - Confirm the specific procedure or CPT code is covered under the plan
  - Review Cigna's Medical Coverage Policies
  - Determine if precertification is required for outpatient services and if it is, obtain precertification through the same website
- Call Cigna Customer Service at the toll-free number on the patient's ID card.

Prior to filing a claim:

- Ensure either your billing staff or vendor includes all critical information needed for Cigna to expeditiously process the claim. Items to include are:
  - Patient name, date of birth, address, gender, and age
  - Health benefits identification number on your patient's ID card
  - Description of the treatment or service (CPT or HCPCS code)
  - Diagnosis code
  - Specific charge for each service
  - Anesthesia time in hours and minutes
  - Medicare or other insurance EOB, if Cigna is the secondary carrier
  - Physician or facility name, address, tax identification number, and National Provider Identifier (if applicable)
  - Physician degree or qualification
  - If billing an unlisted procedure code, a description of the service must be included as well as any clinical notes to support the need for the unlisted code. Both items will expedite the processing of the claim.
- Include modifiers on the claim if they are needed to describe the service performed. To review modifier coverage policies, log in to the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Clinical Reimbursement Policies and Payment Policies > Modifiers and Reimbursement Policies.
- Attach any clinical notes or documentation needed for Cigna to perform a comprehensive review of the claim, including:
  - Letter explaining medical necessity
  - Physician orders, office notes, history, and physical notes
  - Treatment plan or progress notes
  - Facility orders, admission, progress, and discharge notes
  - Test results to include interpretation and report

- Procedure or operative report
- Photos for any cosmetic-related procedures

If you are unsure what documentation is required, Cigna's Customer Service will be glad to assist you.

When you receive the explanation of payment (EOP) or Electronic Remittance Advice (ERA), review it carefully to understand Cigna's reimbursement decisions. If you do not understand the reasons provided on the EOP or ERA, or the decision is different from what was expected, please call Cigna Customer Service at 800.88Cigna (800.882.4462) for assistance.

If it is determined that Cigna made a claim-processing error, the Customer Service Associate will send the claim for correction and no additional action is required by you.

If it is determined that there was an omission or incorrect information was submitted on the claim (e.g., missing field or missing modifier), you will be asked to submit a corrected claim to the address on the participant’s Cigna ID card. Include “Corrected Claim” on the re-submission. The claim will be re-evaluated with this new information.

Dispute Resolution

Provider payment appeals

Unless your participation agreement or state law provides for a different process, the processes in this section apply whenever you have a dispute with Cigna about a payment, including disputes over the amount that you believe you should have been paid and if you think you were not paid in a timely manner.

Before you start the appeals process described below, please call Cigna Customer Service at 800.88Cigna (800.882.4462) to try to resolve the issue first. Many issues can quickly be resolved by providing requested or additional information.

Before calling Cigna, please review the claim and your Cigna Provider Agreement to confirm there is an issue. If you still have a question regarding Cigna's reimbursement decision, you may call Cigna's Customer Service at the toll-free number on the participant's ID card. Please have the information submitted with the claim available when you call: participant's name, date of service, the treating provider's name, and the Tax Identification Number.

If Cigna states the claim has been processed correctly, but you disagree, your next step is to file an appeal with Cigna (or one of our delegates as noted below). Fee schedule or reimbursement terms for multiple patients do not require individual appeals. Please call Cigna Customer Service at 800.88Cigna (800.882.4462) if you need assistance.

Our appeal process is initiated through a written request. This appeal process aims to resolve contractual disputes about post-service payment denials (or partial denials) and other payment disputes. If the issue is not resolved to the provider's satisfaction, you may request dispute resolution, including arbitration, as the final resolution step.

Disputes between the parties arising with respect to the performance or interpretation of the Cigna Provider Agreement will first be resolved in accordance with the applicable internal dispute resolution (appeals) process outlined in the Administrative Guidelines. If the dispute is not resolved through that process, follow the dispute resolution provisions in your Cigna Provider Agreement. The standard dispute resolution process provides that either party may request, in writing, that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of a party's written request for negotiation, either party may initiate arbitration by providing written notice to the other party.

Unless applicable state law provides otherwise, you may not institute arbitration until the provider has completed the internal appeals process.

Note: Cigna uses eviCore healthcare (formerly CareCore | MedSolutions) to manage the precertification review of certain services (e.g., high-technology radiology, diagnostic cardiology, radiation therapy, and musculoskeletal services), as well as appeals for certain of these services when they made the initial clinical determination. As such, in these cases, the provider should appeal directly through eviCore healthcare.

Appeals

All appeals are to be initiated in writing within 180 calendar days of the date of the initial payment or denial decision. If the appeal relates to a payment that Cigna adjusted, the appeal is to be initiated within 180 calendar days from the date of the last payment adjustment.

For additional information on how to submit an appeal, review and follow the Claim Adjustment & Appeals Guidelines on the secure Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Clinical Reimbursement Policies and Payment Policies > Claim Appeals Policies and Procedures > Appeal Policy and Procedures).

Providers should submit all appeal requests on a Request for Provider Payment Review form which can be found on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Forms Center > Medical Forms. The form will help Cigna understand the circumstances around your appeal request.

Appeal types and filing instructions

Contract, fee schedule, and multiple patients disputes

Fee schedule adjustments and reimbursement disputes may not require individual appeals. They may be **quickly** resolved through a real-time adjustment by providing requested or additional information to our Customer Service team. Please call Customer Service at 800.88Cigna (800.882.4462) so we may provide you with further guidance on how to submit these requests.

Claim reimbursement denials

Before submitting the appeal request for claim reimbursement decisions (including NCCI related decisions or mutually exclusive and incidental denials), please review the claim bundling and edit information on the Cigna for Health Care Professionals website using the Clear Claim Connection tool. This tool provides relevant explanations for the claim decisions. If you disagree with the reimbursement after review of the information, submit case specific clinical documentation to substantiate the reason for overriding the bundling or edit decision.

Failure to obtain precertification when required

If the reason on the EOP or ERA was related to failure to obtain precertification, please provide the following in the appeal request (either the Request for Provider Payment Review form or appeal request letter):

- Clinical documentation and Medical records
- Documentation of extenuating circumstances that prevented you from obtaining a precertification

Medical necessity

For medical necessity denials or inpatient facility denials related to level of care, length of stay or delayed treatment days, include the complete facility record (e.g., physician orders, progress notes, patient's medical history and physical exam results, consultations, results of diagnostic testing, operative reports, and discharge summary).

If your dispute involves an issue regarding the medical necessity of a service or procedure in addition to a pricing accuracy concern, a clinician will review the non-

pricing part of your appeal. If your dispute relates to a benefit determination issue in addition to a pricing accuracy issue, the applicable plan's benefits will be reviewed and our response will refer to those benefits.

Most appeals are resolved within 60 calendar days of receipt and notification of our decision will be made to the requesting provider within 75 days unless state law requires a different time frame.

Untimely claim submissions
For any claim denial decisions related to untimely claim submission (failure to submit a claim within 90 days of the date of service), submit justification and supporting documentation for the delay with your appeal request. Acceptable documentation includes the electronic data interchange (EDI) transmission report or evidence that a claim was submitted due to coordination of benefits with another carrier.

If you are disputing the timeliness of your payment, include documentation showing the date you submitted the claim and any communications with Cigna relating to the claim.

For any documentation required under this section, you are responsible for securing the information from any vendors that you might use.

If, after the provider follows with this process, Cigna determines that the initial decision was correct and will be upheld, an appeal denial letter will be sent to you explaining the decision and outlining any additional appeal rights. An appeal determination that overturns the initial decision will be communicated through the explanation of payment with the re-processed claim.

Opioid coverage denial appeals
Opioid appeals should include the prescription name of the opioid drug in the reference field.

Additional payment appeal options
If you are still not satisfied after completing the internal appeal process, you may request dispute resolution including arbitration. This is a binding, final resolution for the regarding claim.

The process for arbitration may be specified in your provider agreement. If it is not specified in your provider agreement and is not prohibited by state law, the following process will apply.

If the dispute is not resolved through the appeal processes described above, either party can initiate arbitration by providing written notice to the other. The appeal processes must be followed in their entirety before initiating arbitration. If one of the parties initiates arbitration, the proceeding will be held in the jurisdiction of the provider's domicile. The parties will jointly appoint a mutually acceptable arbitrator. If the parties are unable to agree upon such an arbitrator within 30 days after one of the parties has notified the other of the desire to submit a dispute for arbitration, then the parties will prepare a Request for a Dispute Resolution List and submit it to the American Health Lawyers Association Alternative Dispute Resolution Service (AHLA ADR Service), along with the appropriate administration fee. Under the Code of Ethics and Rules of Procedure developed by the AHLA ADR Service, the parties will be sent a list of 10 arbitrators

along with a background and experience description, references, and fee schedule for each. The 10 arbitrators will be chosen by the AHLA ADR Service based on their experience in the area of the dispute, geographic location, and other criteria as indicated on the request form. The parties will review the qualifications of the 10 suggested arbitrators and rank them in order of preference from one to nine. Each party has the right to strike one of the names from the list. The person with the lowest total will be appointed to resolve the case.

Each party will assume its own attorney's fees and all of its costs of arbitration; however, the compensation and expenses of the arbitrator along with any administrative fees or costs will be borne equally by the parties. Arbitration is the exclusive remedy for the resolution of disputes under the parties' agreement. The decisions of the arbitrator will be final, conclusive, and binding, and no action at law or in equity may be instituted by the parties other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision will not be consolidated with an arbitration involving other physicians or third parties, and that the arbitrator will be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction.

Determinations for hospital and facility appeals

Unless prohibited by state law, if a hospital or facility fails to request an appeal review, or arbitration of the hospital's or facility's payment or termination dispute within the applicable time frames, Cigna's last determination regarding the dispute will be binding. The hospital or facility should not bill the Cigna plan participant for payments that are denied on the basis that the hospital or facility failed to submit the request for review or arbitration within the required time frames.

Provider termination appeals

On occasion, Cigna deems it necessary to terminate a provider's participation. Appeal rights are offered to providers terminated due to Quality of Care or Quality of Service and providers terminated for failure to meet Cigna credentialing requirements in states that mandate appeal rights be offered. To initiate a review of a provider's termination, submit the following information in writing within 30 calendar days of the date of the provider's termination notice.

- A completed provider termination appeal letter indicating the reason for the appeal
- A copy of the original termination notice
- Supporting documentation for reconsideration

Specialty Networks

We have specialty networks that complement our local provider networks. Requirements for referral and precertification of coverage under these arrangements may vary from standard requirements and can be verified by calling Customer Service at the telephone number on the patient's ID card.

The following specialty networks service the Cigna community. Any state-specific networks are shown in the Market-Specific guides. Please review the state specific information for any requirements specific to your state.

Alabama (AL) *	Alaska (AK) *	Arizona (AZ)
Arkansas (AR) *	California (CA)	Colorado (CO)
Connecticut (CT)	Delaware (DE)	Florida (FL)
Georgia (GA) *	Hawaii (HI) *	Idaho (ID) *
Illinois (IL)	Indiana (IN)	Iowa (IA) *
Kansas (KS)	Kentucky (KY) *	Louisiana (LA)
Maine (ME)	Maryland (MD)	Massachusetts (MA)
Michigan (MI)	Minnesota (MN) *	Mississippi (MS) *
Missouri (MO) St. Louis	Montana (MT)*	Nebraska (NE) *
Nevada (NV)	New Hampshire (NH)	New Jersey (NJ)
New Mexico (NM)	New York (NY)	North Carolina (NC)
North Dakota (ND) *	Ohio (OH)	Oklahoma (OK)
Oregon (OR)	Pennsylvania (PA – Metro Philadelphia) Pennsylvania (PA - Other)	Rhode Island (RI)
South Carolina (SC)	South Dakota (SD) *	Tennessee (TN)
Texas (TX)	Utah (UT)	Vermont (VT)
Virginia (VA)	Virgin Islands (VI)	Washington DC Washington (WA) Washington (Southwest, WA)
West Virginia (Eastern, WV) West Virginia (Western, WV)	Wisconsin (WI)	Wyoming (WY) *

Note: States listed above with an asterisk (*) will use this guide as a reference.

Cigna LifeSOURCE Transplant Network®

Cigna LifeSOURCE Transplant Network includes more than 170 Cigna Centers of Excellence (COE) across the country and the nation's leading medical facilities renowned for their organ and tissue transplantation programs. This exclusive network gives participants with Cigna-administered coverage access to over 800 transplant programs for organ and tissue transplantation committed to managing complex transplant procedures.

To be included in our Transplant Network, programs must meet our annual quality guidelines for being in the upper half of the relative performance index in their region for adult graft and patient survival rates, management of the wait list in regards to mortality and transplant rate, and minimum volumes, as well as transplant team training and experience.

Transplant and related specialty programs are included in our network at one of the following levels of participation:

1. **Program of Excellence:** To be designated and approved to be in our top tier Program of Excellence (POE), each solid organ transplant program is reviewed and must be ranked in the top 50th percentile in their region based on the new Relative Performance Index. All programs must maintain minimum volumes, patient and graft survival outcomes and accreditations to be designated as a POE. Each bone marrow/stem cell transplant must also meet or exceed the minimum 100-day outcomes. Additional details are included in the document Cigna LifeSOURCE Guidelines for Participation on our website https://cignalifesource.com. Please note, not every transplant program at a Cigna LifeSOURCE participating facility may meet all the POE minimum guidelines at a given time.
2. **Supplemental:** Programs not meeting the POE designation are eligible for consideration as a Supplemental or provisional participating program, which is our second tier. This solution was developed due to client requests for access to certain transplant programs outside of the POEs. While not meeting the more stringent POE standards, these programs must have Centers for Medicaid and Medicare (CMS) certification for solid organs, and Foundation for Accreditation of Cellular Therapy (FACT) and National Marrow Donor Program (NMDP) accreditation for bone marrow/stem cell transplants. There are no minimum volumes or outcomes that must be met. Solid organ transplant programs must demonstrate their ability to maintain CMS certification - if the certification is in jeopardy or has been suspended for any reason; the program may lose its Supplemental designation and will no longer be a participating program in the Cigna LifeSOURCE Transplant Network.
3. **Ventricular Assist Device (VAD) Network:** The VAD Network was created to fill the need for people who are determined to not be a candidate for heart transplant, but are a candidate for a Ventricular Assist Device used for Destination Therapy. The heart transplant program must be contracted as a Program of Excellence in the Cigna LifeSOURCE Transplant Network in order for the VAD program to be included in the Cigna LifeSOURCE VAD Network. The VAD program must obtain and maintain CMS certification for Destination Therapy and hold accreditation by the Joint Commission or DNV Health Care.

The programs currently participating in the VAD Network can be found on the Programs of Excellence list on the https://cignalifesource.com website.

All our contracted facilities are reviewed annually. As a result, they may move from one level of participation to the other, or may be removed altogether from being a participating facility in the LifeSOURCE network. Please review our LifeSOURCE Guidelines for Participation, as well as the Cigna LifeSOURCE Relative Performance Index Methodology paper for additional information on our website at https://cignalifesource.com.

The Cigna LifeSOURCE team includes experienced, dedicated staff with transplant-specific knowledge in case management, contracting, benefit design support, quality assurance, claims re-pricing, and clinical support. This includes two full-time dedicated medical directors with backgrounds in transplantation. Cigna LifeSOURCE conducts extensive annual reviews to help ensure transplant facilities maintain quality standards.

Participants with Cigna-administered coverage who are organ or tissue transplant candidates are assigned specially trained nurse transplant case managers who coordinate care services. These nurses typically have a background in critical care or transplantation and receive extensive training as transplant case managers.

For information about the Cigna Life*S*OURCE Transplant Network:

- Visit Cigna LifeSOURCE online at https://cignalifesource.com. Here, you can find the list of Programs of Excellence and Supplemental Cigna LifeSOURCE participating facilities by clicking on “I Want to Find a Facility” and information about our quality guidelines by clicking on “Find Out More” under the Health Care Providers section.
- E-mail Cigna LifeSOURCE at LifeSOURCEweb@cigna.com.
- Call the Cigna LifeSOURCE Transplant Case Management Department at 800.668.9682.

Cigna Behavioral Health

Cigna Behavioral Health participants only

Cigna Behavioral Health, Inc., our mental health and substance use disorder company, provides programs and case management services to most customers with medical benefits through Cigna. We provide behavioral care benefit management, employee assistance, and work/life programs.

Cigna's behavioral health benefits are managed through regional care centers where our staff performs telephone intake, patient registration, care management, and provider relations activities. We provide access to behavioral health services through a network of independently contracted providers, behavioral health facilities, and chemical dependency facilities.

To arrange or confirm an inpatient referral or psychiatric consultation, please contact Cigna Behavioral Health at the Customer Service phone number on the patient’s ID card. Our regular hours of operation for routine business are Monday through Friday, 8:30 a.m. to 5:00 p.m. CST. Additionally, advocates and care managers are available 24 hours a day for clinical emergencies.

For more information on Cigna Behavioral Health, visit our website at CignaforHCP.com > Resources > Behavioral Resources. To find a participating behavioral provider, visit Cigna.com > Find a Doctor, Dentist or Facility.

Cigna Gene Therapy Program

The Cigna Gene Therapy Program directs customers to participating providers to ensure they receive coverage for cost-efficient, quality care and services. Features of the gene therapy program include:

- Gene therapy benefit language that provides coverage for in-network services only (except where prohibited by state regulations) and a travel benefit for customers traveling more than 60 miles from home.
- Dedicated gene therapy case management, which provides high-touch, comprehensive end-to-end case management.
- Providers who have manufacturer access to gene therapies and have contracted with us to participate in the Cigna Gene Therapy Program.

Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease. Cigna considers the following factors when designating a product as gene therapy:

- Mechanism of action is one of the following:
    - Replacing a disease-causing gene with a healthy copy of the gene.
    - Inactivating a disease-causing gene that may not be functioning properly.
    - Introducing a new or modified gene into the body to help treat a disease.
- Specific product dispensing, administration, monitoring, and other requirements.
- Provider administration requirements.
- Special handling provisions.

Note that the presence of any one of these factors does not guarantee that Cigna will designate a pharmaceutical product as gene therapy.

Due to the complexities and therapeutic nuances specific to genetic conditions, each gene therapy will require a customized management approach. Coverage of gene therapy products and administration services is determined by a customer's benefit plan. Cigna will cover gene therapies for eligible customers when medical necessity requirements are met.

Participating providers

Cigna will contract, directly or indirectly, with select providers for each gene therapy product introduced to the market. These providers will be designated as participating providers in the Cigna Gene Therapy Program.

Cigna will not reimburse providers who purchase gene therapy products on their own from specialty pharmacies, manufacturers, or wholesalers. Cigna covers gene therapies when authorized or otherwise determined to be medically necessary. Gene therapy products must be dispensed and a specialty pharmacy or other provider with which Cigna has a reimbursement arrangement must submit their claims.

Additional information

To access the current list of Cigna-designated gene therapy products, providers can log in to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Precertification Policies > Cigna Designated Gene Therapy Products Requiring Precertification).

To access the current list of Cigna Gene Therapy Program participating providers, providers can log in to CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Precertification Policies > Cigna Gene Therapy Program Participating Providers.

Embarc Benefit Protection and Gene Therapy

Embarc Benefit Protection℠ is a network solution providing financial protection for customers who need select gene therapies. Employer groups and health plans may purchase this solution.

Providers will be required to bill eviCore healthcare directly for the gene therapy product only and will follow the standard claims submission process for charges attributable to gene therapy administration. The prior authorization approval letter will include notification when the customer has Embarc Benefit Protection.

For a list of the gene therapies included in Embarc Benefit Protection, providers can log in to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Reimbursement and Payment Policies > Precertification Policies > Cigna Designated Gene Therapy Products Requiring Precertification).

National Ancillaries

Cigna's national ancillary programs directly respond to our customer and employer group requests for access to cost-effective, quality services and to stay more informed on health care options.

To achieve these goals, we collaborate with select ancillaries, like those listed below,* to help ensure services are medically necessary and that quality care is received.

Program goals

Our goals include the following:

- Expand access to quality providers.
- Increase quality of care and patient safety.
- Educate customers about their health care options.
- Administer services in accordance with plan benefits and applicable coverage/reimbursement policies.

Service	Ancillary	Description	Contact information
Chiropractic care	American Specialty Health	American Specialty Health (ASH) provides chiropractic network management, utilization management, and claims management services for individuals with Cigna coverage in certain markets. ASH performs medical necessity review and provides a network of chiropractors for Cigna customers with Commercial Health Maintenance Organization, Network, Point of Service, Open Access, Open Access Plus, Preferred Provider Organization, and LocalPlus medical benefit plans. ASH also reviews claims from nonparticipating chiropractors for medical necessity. Providers must be contracted with ASH to provide in-network chiropractic services to individuals with Cigna coverage in affected markets.	Phone: 800.972.4226 Website: americanspecialtyhealth.com
Dialysis	DaVita Fresenius Medical Center U.S. Renal Care	DaVita, Fresenius Medical Care, and U.S. Renal Care provide access to a network of dialysis centers for individuals with Cigna coverage and provide numerous services, including hemodialysis, peritoneal dialysis, transplant support, nutritional counseling, laboratory testing, and various supplies. They are both recognized nationally as leading providers of dialysis services, providing care for patients with chronic kidney failure and end-stage renal disease.	**DaVita** Phone: 800.244.0680 Website: DaVita.com **Fresenius Medical Care** Phone: 800.662.1237 Website: freseniuskidneycare.com **U.S. Renal Care** Phone: 866.671.8772 Website: usrenalcare.com

Durable medical equipment , home health care, and infusion therapy services	CareCentrix	CareCentrix (CCx) provides durable medical equipment (DME), home healthcare, and home infusion therapy services for Cigna customers. Providers can set up coordination of home care services through CCx's credentialed provider network. This service is available 24 hours a day, 365 days a year. CCx arranges the following care and services for customers in the comfort of their home: • DME (beds, standard wheelchairs, scooters, walkers, etc.) • Breast-feeding equipment and supplies • Home health care (nursing, therapy services, social work, and home health aides) • Home infusion products • Insulin pumps and related supplies, continuous passive motion devices, wound suction devices, Pro time monitors, and DynaMaps • Respiratory equipment (oxygen, continuous positive airway pressure, and ventilators) • Enteral nutrition (pumps and nutritional support) • Custom-powered wheelchairs and scooters	Phone: 844.457.9810 Website: carecentrixportal.com
Gastroenterology	eviCore healthcare	eviCore healthcare (eviCore) administers precertification for the following gastroenterology procedures for most customers with Cigna Connect Individual & Family Plans, and Cigna Employer account: • Esophagoscopy • Esophagogastroduodenoscopy • Most capsule endoscopies Providers must submit precertification requests for these services directly to eviCore.	Phone: 866.668.9250 Website: eviCore.com/Cigna
Hearing	Amplifon Hearing Health Care	Amplifon Hearing Health Care (formerly HearPO) acts as our exclusive in-network point of contact for providers to access digital and digitally programmable analog hearing devices and supplies for individuals with Cigna coverage (this includes Shared Administration Repricing and Payor Solutions customers). Providers are required to work with Amplifon Hearing Health Care to order digital and digitally programmable analog hearing devices and supplies for their Cigna patients who have hearing aid benefit coverage. Providers are not allowed to bill for hearing aids. This is because there is no cost to the provider when ordering through Amplifon Hearing Health Care. Amplifon Hearing Health Care will pay the manufacturer directly for the hearing aids. All digital and digitally programmable analog hearing devices and supplies that are not ordered through Amplifon Hearing Health Care for affected customers will be denied, and customers cannot be billed.	Phone: 855.531.4696 Website: amplifonusa.com/cigna

High-tech radiology and diagnostic cardiology	eviCore healthcare	eviCore healthcare (eviCore) provides high quality, cost-effective benefit management services to Cigna customers in most markets for outpatient, nonemergency, high-tech radiology (e.g., computed tomography scans, magnetic resonance imaging, positron emission tomography scans), and diagnostic cardiology services. Providers must request precertification through eviCore for these services for their patients with Cigna coverage. The radiology precertification process features improved customer service through the Informed Choice program. eviCore may contact individuals with Cigna coverage to inform them of available participating radiology service providers. We also use eviCore to provide an in-office credentialing program for low-tech radiology services in the Connecticut, New Jersey, and New York markets.	Phone: 888.693.3211 Website: eviCore.com/Cigna
Integrated Oncology Management Program	eviCore healthcare	eviCore healthcare (eviCore) administers precertification for medical oncology medications, including primary chemotherapy and supportive drugs (e.g., medical injectables and infusions) as well as oral chemotherapy medications, for individuals with Cigna coverage. Providers must request precertification for these services directly from eviCore.	Phone: 866.688.9250 Website: eviCore.com/Cigna

Laboratory	Laboratory Corporation of America® Quest Diagnostics, Inc.®	We currently contract with numerous local and national laboratories, including Laboratory Corporation of America and Quest Diagnostics, Inc., as well as other reference, pathology, genetic, and esoteric laboratories, to provide access to quality services at in-network, cost-effective rates. By referring patients to a laboratory that participates in our network, providers help ensure their patients maximize the benefits under their Cigna plan while limiting their out-of-pocket expenses. For a complete list of participating laboratories, visit the provider directory on our Cigna website (Cigna.com > Find a Doctor, Dentist, or Facility).	**Laboratory Corporation of America** Phone: 888.LABCORP Website: labcorp.com **Quest Diagnostics, Inc.** Phone: 866.MyQuest Website: questdiagnostics.com
Musculoskeletal and pain management services	eviCore healthcare	eviCore healthcare (eviCore) administers precertification for inpatient and outpatient musculoskeletal and pain management services for Cigna's customers in most markets. Providers must request precertification directly from eviCore for these services in the program, including for major joint surgery services related to the hip, knee, and shoulder and interventional pain management services.	Phone: 888.693.3297 Website: eviCore.com/Cigna
Orthotics and prosthetics	Linkia	Linkia provides individuals with Cigna coverage access to a network of orthotic and prosthetic (O&P) providers. Providers should request precertification through Cigna and work directly with Linkia so they can coordinate and manage all O&P needs for their patients with Cigna coverage. **Note**: Cigna also maintains separate in-network relationships with several nationally located O&P groups, including DJ Orthopedics, Zimmer Biomet, and Cranial Technologies.	Phone: 877.754.6542 Website: linkia.com
Physical and occupational therapy	American Specialty Health	American Specialty Health (ASH) provides physical and occupational therapy (PT/OT) network management for individual office locations, utilization management, and claims management services for individuals with Cigna coverage in certain markets. ASH also reviews claims from non-participating PT/OT providers for medical necessity. Physical and occupational therapy care centers must be contracted with ASH to provide in-network PT/OT services to individuals with Cigna coverage in affected markets.	Phone: 800.972.4226 Website: americanspecialtyhealth.com

Radiation therapy	eviCore healthcare	eviCore healthcare (eviCore) administers precertification for select radiation therapy services for individuals with Cigna coverage. Providers must request precertification for these services directly from eviCore.	Phone: 866.686.4452 Website: eviCore.com/Cigna
Sleep management services	CareCentrix	CareCentrix (CCx) provides a comprehensive sleep management program for individuals with Cigna coverage. As part of this program, CCx provides individuals with access to its robust network of sleep therapy providers, which includes expanded access to sleep testing services in the comfort of the patient's home. Providers must request precertification for certain sleep testing services through CCx. During the precertification process, we apply medical necessity and place-of-service determinations for these services.	Phone: 877.877.9899 Website: Cigna.SleepCCX.com
Vision services	Vision Services Plan	Vision Services Plan (VSP) is our delegated third-party administrator provider of in-network routine eye exams and eyewear services. Providers must contract with VSP to provide in-network routine eye exams and eyewear services to individuals in all markets with Cigna Preferred Provider Organization (PPO) vision coverage. Individuals with Cigna's PPO vision coverage may self-refer to a participating VSP provider for routine vision exams and eyewear as allowed by their Cigna plan.	Phone: 800.877.7195 Website: vsp.com

* List is not all-inclusive of every national ancillary provider. Ancillary providers do not manage services in all states and markets.

Participant Information

Participants receive a Cigna ID card that includes an identification number, designated copayments information, coinsurance and deductibles, and the PCP name assigned to the participant, if applicable. The ID card does not guarantee eligibility or coverage.

Review the ID card every time a participant visits your office. To obtain eligibility information based on our current records:

- Log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com) > Patients > Search Patients. If you are not registered for the website, go to CignaforHCP.com and click “Register Now.”
- Submit an eligibility and benefit inquiry (270/271) through your EDI vendor.
- Call the Customer Service number on the participant’s ID card.
- Call Cigna Customer Service at 800.88Cigna (882.4462) or for your patients with “G” ID cards, call 866.494.2111.

If a participant does not have an ID card or enrollment form, call 800.88Cigna (800.882.4462) or 866.494.2111.

Cigna makes no representations or guarantees about the number of participants referred to a provider. Cigna also reserves the right to direct participants to select participating providers and to influence participants’ choice of participating provider.

Alternate member identifier (AMI)

To help protect the privacy of participants and prevent identity theft, Cigna has phased out the use of Social Security numbers (SSN) as the participant identifier. Use the identifier on the participant’s ID card to submit claims and to inquire about eligibility or claim status. Cigna continues to accept claims and inquiries submitted with either the AMI or the subscriber SSN for participants with an AMI.

Note: Many of the identifiers begin with U0 (zero). In some cases, when entering the identification number the capital letter ‘O’ is being input instead of the number “0” (zero). If your Cigna claim submissions are rejected for “invalid ID,” check that you have entered the correct identifier – U0 (zero), rather than UO (capital letter O).

In addition, you may submit the subscriber ID with or without the subscriber relationship suffix shown on the participant ID card (e.g., U01234567 01).

Verification options

For information on a participant’s benefit plan, including copayments, coinsurance, or deductible amounts:

- Review the participant’s ID card
- Submit an eligibility and benefit (270/271) inquiry through Post-N-Track web service or other EDI vendor
- Log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com) > Patients > Search Patients, or call 800.88Cigna (800.882.4462)

Participant concern or complaint

A participant should contact Cigna if they have a concern or complaint about administration, coverage, or exclusions in their benefit plan, or the quality of service or care received. An attempt will be made to resolve the problem during the first telephone call. If a participant is not satisfied with our response, he/she may follow the processes for submitting a complaint outlined in his/her benefit plan document. The process may include contact from a Cigna representative to a provider to obtain information that may help in the resolution of the concern or complaint. This also provides an opportunity for the provider to respond to the concern or complaint.

Provider cooperation

A participant may ask for your assistance with regard to an appeal. We encourage you to assist the participant by providing all relevant clinical records or a statement on behalf of the participant.

Cigna may contact you during the review and investigation of a participant's concern, complaint, or appeal. Information or written statements may be requested. You are required to cooperate and assist with the resolution and appeals process within the time periods requested to help ensure a full and fair review and so Cigna is compliant with applicable laws.

Either a participant or a Cigna representative may ask for your assistance with regard to an appeal, Quality of Care and/or Quality of Service complaint. To best address and/or resolve the participant's concern or appeal, we encourage timely submission of all relevant requested information.

If you believe an accelerated timeframe is needed and it meets the expedited criteria, an Expedited Appeal may be requested on behalf of the patient. An Expedited Appeal is available when:

- Participant's treating provider believes that processing the appeal request under the pre-service standard timeframes might jeopardize life, health, or ability to regain maximum functionality.
- Due to failure to authorize an admission or continuing inpatient hospital stay for a participant who has received emergency services, but has not been discharged from a facility.
- Participant's treating provider, with knowledge of the participant's medical condition, believes that by processing the appeal request under the pre-service standard timeframes it would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Contact Cigna at the telephone number on the patient's ID card to initiate the process and obtain expedited filing instructions. If faxing your request, include "expedited" in the reference field of the appeal fax cover sheet as well as the actual appeal itself. If your request is for a pharmacy appeal, include the name of the drug.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 law ensures the portability of insurance coverage to protect patients from “prior condition” limits due to changes in employment or coverage.

The Administrative Simplification provisions of HIPAA include regulations about privacy, standard code sets and transactions, security and unique health identifiers. They were designed to safeguard a patient’s Protected Health Information (PHI), standardize the transmission of certain common transactions between health care entities, and standardize the medical codes used in those transactions. These standardization rules help reduce health care administrative costs.

We are committed to maintaining the confidentiality of participant PHI. We have established policies and procedures to protect oral, written, and electronic PHI. Our Notice of Privacy Practices describes how we use and disclose PHI and advises participants of their rights under federal and state laws. For a copy of the notice, visit Cigna.com/general/misc/privacy.html or call 800.88Cigna (882.4462).

Cigna expects you to be compliant with HIPAA and other applicable state confidentiality laws.

Security regulations

The HIPAA standards for the security of electronic health information specifies a series of administrative, technical, and physical security procedures for covered entities to use to ensure the confidentiality, integrity, and availability of electronic protected health information.

Refer to Cigna.com (Health Care Professionals > Resources > News from Cigna > HIPAA: Special Information for Providers) to learn more about HIPAA for providers).

National Provider Identifier

The National Provider Identifier (NPI) is a unique identification number for use in standard health care transactions. It is a number issued to providers and covered entities that transmit standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transactions (such as electronic claims and claim status inquiries). The Centers for Medicare & Medicaid Services (CMS) began issuing NPIs to providers that applied and qualified in May 2005. Providers and covered entities may apply for NPIs through the National Plan and Provider Enumeration System (NPPES) established by CMS for this purpose.

- Type 1 NPIs are assigned to individual practitioners, e.g., physicians, dentists, nurses, chiropractors, pharmacists, and physical therapists
- Type 2 NPIs are assigned to organizations, e.g., hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, and pharmacies

The NPI fulfills a requirement of HIPAA, and must be used by health plans, providers, and health care EDI vendors in HIPAA standard electronic transactions. The NPI is intended to:

- Replace other identifiers previously used by providers and assigned by payers (e.g., Unique Physician Identification Number [UPIN], Medicare or Medicaid numbers)
- Establish a national standard and unique identifier for all providers
- Simplify health care system administration
- Encourage the electronic transmission of health care information

Cigna accepts the NPI on standard HIPAA transactions as outlined below. This approach should not be confused with any guidance specific to Medicare claims requirements.

837 electronic claims

- The “Billing Provider” Taxpayer Identification Number (TIN) and NPI are required. Any additional provider identification on the claim, such as the “Rendering Provider” or “Referring Provider” must include the name and NPI when submitted.
- An organization may have more than one organization or type 2 NPI. Use the most appropriate organizational NPI as your primary identifier when submitting the "Billing Provider" on claims. The TIN must be submitted as the secondary provider identifier. This TIN is the number used on the Internal Revenue Service (IRS) form 1099, which is either the Employer Identification Number (EIN) for organizations, or the Social Security number (SSN) for individuals; both an EIN and SSN number should not be included concurrently. Other identifiers, such as Medicare provider number, are considered "legacy" identifiers and should not be included.
- Submission of the “Billing Provider” TIN on the electronic claim is a HIPAA requirement. The National EDI Transaction Set Implementation Guide specifically states:

  “If 'code XX - NPI' is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop. The number sent is the one which is used on the 1099.”
- Under HIPAA Accredited Standards Committee (ASC) X12 5010 standards, “Pay to Provider” information is limited to an alternate address only. No additional identifiers, neither TIN nor NPI, are permitted. The “Pay to Provider” address is only needed if it is different from that of the “Billing Provider.”
- Cigna will reject electronic claims received without a NPI unless the submitter is ineligible to receive a NPI. If you are not eligible to receive a NPI, notify Cigna by updating your demographics.
- As with any change to your billing process, if you or your organization plan to change the way claims are submitted to Cigna because of your NPI implementation or enumeration, please notify Cigna of this change. One example would be an organization that has enumerated multiple NPI subparts and will start to bill using the "new" subpart providers.

835 electronic remittance advice

- Prior to October 2013, Cigna included the "Billing Provider" NPI on the 835. If more than one claim was included in a single 835, the NPI from the first claim included in the remittance was returned as the “Payee” NPI. The NPI for the "Rendering

Provider" was included in the 835, if the "Rendering Provider" NPI was submitted on the 837 electronic claim.

- Since October 2013:
  - For claims paid by check or EFT with TIN bulking, we group the claims within the 835 remittance by the “Billing Provider” NPI submitted on the original claim(s). A Provider Summary (TS3) field is added to the 835 and includes the “Billing Provider” NPI to help providers easily reconcile their payments.
  - For claims paid by EFT with NPI bulking, a separate 835 is sent for each NPI with the “Billing Provider” NPI returned as the “Payee” NPI. A Provider Summary (TS3) field is also added to the 835 and will include the “Billing Provider” NPI to help providers easily reconcile their payments.
  - The NPI for the "Rendering Provider" is included in the 835 regardless of bulking preference, if the "Rendering Provider" NPI was submitted on the 837 electronic claim.

Real-time request transactions (270, 276, 278)

- All eligibility and benefit inquiries (270) transactions should be submitted with either a type 1 (individual) or type 2 (organizational) NPI. We will also accept a 270 submitted with a TIN.
- For professional or dental claim status inquiries (276), the “Billing Provider” or “Rendering Provider” NPI from the submitted claim should be used to inquire on claim status.
- For institutional claim status inquiries (276), the “Billing Provider” NPI from the submitted claim should be used to inquire on claim status.
- For all claim types, we will also continue to accept claim status inquiries (276) using the TIN from the submitted claim.
- Health Care Services Review — Request for Review (278) transactions should include the NPI or TIN to identify any providers included in the request.
- Providers should contact their EDI vendor for details regarding the submission of NPI on these transactions.

Additional information is available on CignaforHCP.com > Resources > Medical Resources > Doing Business with Cigna> National Provider Identifier (NPI) FAQs.

Cigna Customers’ Rights and Responsibilities Statement

As a Cigna customer, you have certain rights and responsibilities.

You have the right to:

- Receive coverage for the benefits and treatment available under your health benefit plan when you need it, and in a way that respects your privacy and dignity.
- Receive the understandable information you need about your health benefit plan, including information about services that are covered and not covered and any costs that you will be responsible for paying.
- Obtain understandable information about Cigna's programs and services, including the qualifications of staff that support Cigna wellness and similar programs, and any contractual relationships related to such programs.
- Access current information on in-network health care providers, places you can receive care, and information about a particular provider’s education, training and practice.

- Select a primary care provider for yourself and each covered member of your family, and change your primary care provider for any reason. However, many benefit plans do not require that you select a primary care provider.
- Keep your personal identifiable data and medical information kept confidential by Cigna and your health care provider, know who has access to your information, and know the procedures used to ensure security, privacy, and confidentiality. Cigna honors the confidentiality of its customers' information and adheres to all federal and state regulations regarding confidentiality and the release of personal health information.
- Participate with your health care provider in health decisions and have your health care provider give you information about your condition and your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language you understand.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.
- Refuse medical or behavioral care. If you refuse care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your health care provider. Your health care provider can give you advice, but you will have the final decision.
- Be advised of who is available to assist you with any special Cigna programs or services you may receive and who can assist you with any requests to change or disenroll from programs or services offered by or through Cigna.
- Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about Cigna and/or the quality of care you receive from health care providers and the various places you receive care in our network; provide a courteous, prompt response; and guide you through our grievance process if you do not agree with our decision. Cigna strives to resolve your complaint on initial contact and in a manner that is consistent with your applicable benefit plan. Language interpretation and TTY services are available for complaint and appeal processes.
- Know and make recommendations regarding our policies that affect your rights and responsibilities. If you have recommendations or concerns, please call Customer Service at the toll-free number on your ID card.

You have the responsibility to:

- Review and understand the information you receive about your health benefit plan. Please call Customer Service when you have questions or concerns.
- Understand how to obtain services and supplies that are covered under your plan, including any emergency services needed outside of normal business hours or when you are away from your usual place of residence or work, by using the indicated number on your Cigna ID card, or by accessing Cigna on-line resources.
- Show your ID card before you receive care.
- Schedule a new patient appointment with any in-network health care provider; build a comfortable relationship with your provider; ask questions about things you don't understand; and follow your health care provider's advice. You should understand that your condition may not improve and may even get worse if you don't follow your health care provider's advice.
- Understand your health condition and work with your health care provider to develop treatment goals that you both agree on, and to follow the treatment plan and instructions.

- Provide honest, complete information to Cigna and the health care providers caring for you.
- Know what medicine you take, why and how to take it.
- Pay all copays, deductibles and coinsurance for which you are responsible, at the time service is rendered or when they are due.
- Keep scheduled appointments, and notify the health care provider's office ahead of time if you are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by your plan.
- Voice your opinions, concerns or complaints to Cigna Customer Service and/or your health care provider.
- Notify your plan administrator and treating health care provider as soon as possible about any changes in family size, address, phone number or status with your health benefit plan, or if you decide to disenroll from Cigna's programs and services.

Prescription Drug Program

This information pertains to physicians and other providers

Cigna offers a prescription drug benefit program where, in order to be covered, participants generally are required to purchase prescription drugs from Cigna participating pharmacies or from our home delivery pharmacy. Drugs are supplied per prescription order or refilled in quantities normally prescribed up to a 30-day supply or as defined by Cigna, the Federal Drug Administration (FDA), or applicable law. Up to a 90-day supply of maintenance medication may be dispensed through the home delivery prescription drug program or obtained from designated pharmacies if the participant's benefit plan provides for a 90-day supply at a local retail pharmacy.

Cigna requires that generic equivalents be dispensed in place of brand-name drugs, as available and as appropriate in the clinical judgment of a provider. Participants who prefer a brand-name drug rather than its generic equivalent may be subject to a higher copayment.

Plan options

This information pertains to physicians and other providers

Cigna's prescription drug lists

To access Cigna's prescription drug lists, log in to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Drug list).

Participants who have a Cigna pharmacy benefit are enrolled in one of the following plans that may include either dollar copayment or percentage coinsurance amounts. Some plans may require a deductible be met prior to paying a copayment or coinsurance amount and may be subject to a maximum out-of-pocket limit. Some plans may require customers to pay a significantly higher cost if an available generic medication is not dispensed.

- **Three-tier plan:** Participants in the three-tier prescription drug plan have three copayment levels, depending on a drug's assigned category on the Cigna prescription drug list or formulary.
    - Generic, or first-tier, drugs have the lowest copayment.
    - Preferred brand-name drugs with no generic equivalent, or second-tier drugs, have a higher copayment.
    - Third-tier drugs have the highest copayment and generally have equally effective and less-costly generic alternatives and/or one or more preferred brand-name options.
- **Four-tier plan:** Participants in the four-tier prescription drug plan have four copayment levels, depending on the drug's assigned category on the Cigna prescription drug list or preferred brand.
    - Generic, or first-tier, drugs have the lowest copayment.

  - Preferred brand-name drugs with no generic equivalent, or second-tier drugs, have a higher copayment.
  - Third-tier drugs are covered at the third-tier copayment and generally have equally effective and less-costly generic alternatives and/or one or more preferred brand-name options.
  - The fourth tier consists of only self-administered injectables specialty medications or oral and self-administered specialty medications.

- **Five-tier plan:** Participants in the five-tier prescription drug plans offered to Individual & Family plans have five customer cost share levels, depending on the drug's assigned category on the Cigna prescription drug list.
  - Preferred generic, or first-tier, drugs have the lowest cost share and contain low-cost generic medications.
  - Non-preferred generic, or second-tier, drugs have a higher cost share than tier-one generics.
  - Preferred brand-name drugs with no generic equivalent, or third-tier drugs, have a higher copayment than tier-two generics.
  - Fourth-tier drugs are covered at the fourth-tier cost share and include non-preferred brand names that have equally effective and less-costly generic equivalents or have one or more preferred brand-name options.
  - The fifth tier consists of oral and self-administered injectables considered specialty in nature. These injectables are covered at the fifth tier cost share amount.

Participants with "G" ID Cards:
Plan options are based on three and four-tier plans:

- **Three-tier plan:** Participants in the three-tier prescription drug plan have three copayment levels, depending on a drug's assigned category on the Cigna prescription drug list or formulary.
  - Generic, or first-tier, drugs have the lowest copayment.
  - Preferred brand-name drugs with no generic equivalent, or second-tier drugs, have a higher copayment
  - Third-tier drugs have the highest copayment and generally have equally effective and less-costly generic alternatives and/or one or more preferred brand-name options.
- **Four-tier plan:** Participants in the four-tier prescription drug plan have four copayment levels, depending on the drug's assigned category on the Cigna prescription drug list or preferred brand.
  - Generic, first-tier, drugs have the lowest copayment.
  - Preferred brand-name drugs with no generic equivalent, or second-tier drugs, have a higher copayment.

- Third-tier drugs are covered at the third-tier copayment and generally have equally effective and less-costly generic alternatives and/or one or more preferred brand-name options.
- The fourth-tier category consists of self-administered injectables or specialty medications. *Note that fourth-tier drug list information is available by logging in to CignaforHCP.com.*

Preventive prescription drug option

Under some plans that have a deductible, participants may not be required to pay the deductible for preventive medications. Preventive medications are those prescribed to prevent the occurrence of a disease or condition for individuals with risk factors. Preventive medications can include those used for the prevention of conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke, and prenatal nutrient deficiency. Preventive medications can be found on the drug lists on Cigna.com.

If you have questions about our Prescription Drug Program, call 800.88Cigna (882.4462).

Prescription drug list

This information pertains to physicians and other providers

The prescription drug list) is a subset of the top drugs and therapeutic classes from the Cigna drug list. This preferred list of medications approved by the U.S. Food and Drug Administration (FDA) is the foundation of the Cigna prescription drug program. You may access the entire drug list by logging in to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Drug List), or by calling 800.88Cigna (800.882.4462) to request a paper copy.

Cigna regularly updates this drug list to reflect any changes to covered prescription drugs (e.g., brand-name medications may change tiers or may no longer be covered).

For most customers, Cigna Pharmacy Management makes changes to the prescription drug lists on January 1 and July 1 of each year to help lower costs for our customers. As a result of such changes, certain high cost medications may no longer be covered. Cigna encourages the use of lower-cost generic or preferred brand alternatives, when appropriate.

The coverage status of a prescription drug may change periodically for various reasons. For example, a prescription drug may be removed from the market, a new prescription drug in the same therapeutic class as a prescription drug may become available, or other market events may occur. Market events, such as an increase in acquisition cost of a prescription drug, may affect the coverage status of a prescription drug. As a result of coverage changes, the benefit plans may require customers to pay more or less for the prescription drug, obtain the prescription drug from certain pharmacy (ies), or try another covered prescription drug first.

In addition, newly approved FDA drug products available in the marketplace may not be covered for the first six months after approval to allow time for a thorough clinical review.

This includes medications, medical supplies, or devices that are covered under standard pharmacy benefit plans. If currently available medications/therapies are not appropriate, providers can request coverage through a medical necessity review process during this interim review period.

Medications requiring prior authorization (medical necessity request process)

Physicians and pharmacies in the Cigna network are responsible for following the Cigna prescription drug list outpatient drug formulary. You are required to contact the pharmacy service center to request prior authorization if any of the following apply:

- A generic or preferred drug should not be prescribed in your medical judgment for a patient.
- The patient has a closed-formulary benefit plan.
- The medication is not covered on the plan formulary.
- The prescribed drug requires prior approval of coverage.
- You have several options for submitting prior authorization requests.

• Fax: – Cigna ID cards: 800.390.9745 – "G" ID cards: 866.960.7716
• Your ePrescribing software: Cigna Home Delivery Pharmacy (pharmacy name)
• Electronic health record (EHR) or electronic medical record (EMR): ○ CoverMyMeds® ○ Surescripts® • Online submission: CoverMyMeds/epa/Cigna
• Phone: – Cigna ID cards: 800.Cigna24 (244.6224) – "G" ID cards: 866.265.6578

Information fields must be complete and legible on the submitted request. The review process may take 48 hours. Incomplete forms will be denied or returned for illegible or missing information. Requests marked as urgent will be reviewed the same day they are received.

A copy of the Cigna prescription coverage request form is available on the Cigna for Health Care Professionals website (CignaforHCP.com > Get questions answered: Resource> Pharmacy Resources > Communications: View Documents > Prior Authorization Forms).

Real-time benefit check

Real-time benefit check gives you access to patient-specific drug benefit information through your electronic medical record (EMR) or electronic health record (EHR) system during the integrated ePrescribing process. This service enables you to access drug benefit details, including:

- Coverage status (e.g., prior authorization, step therapy, quantity limits).
- Cost shares at the specific point in the deductible phase and out-of-pocket maximum.
- Pharmacy options and cost (i.e., 30- and 90-day retail or 90-day mail).
- Therapeutic alternatives with costs.

Provider and patient benefits

Real-time benefit check provides:

- Proactive patient/prescriber decision-making opportunities.
- Drug cost savings by guiding to lower-cost, covered drug alternatives.
- Cost information and, if applicable, prior authorization requirements during the prescribing process to reduce the potential for surprises at the pharmacy counter.

EMR or EHR system requirements

To access real-time benefit check, you must have the most current version of your vendor's EMR or EHR system, and the system must be contracted with Surescripts®. For information about how to implement, access, and view messages and to get started, contact your EMR or EHR vendor.*

Best practices

- Make sure eligibility files are up to date.
- Get regular updates to ePrescribing drug reference files.
- Encourage adoption of real-time benefit check within your practices.

Some providers have reported spending less time on prior authorizations due to real-time benefit check providing alternatives that do not require prior authorization.

*EMR vendor may refer to real-time benefit check as cost estimator, formulary and benefit, or real-time prescription benefit.

Electronic prior authorization

When your treatment plan includes certain prescription drugs, your patient's pharmacy benefit may require that you request prior authorization. You can speed up this process by requesting it electronically.

Electronic prior authorization (ePA) can save you time by eliminating the forms, faxes, and phone calls associated with manual requests and can provide you with faster coverage determinations. As an added benefit, your patients will have faster access to their drug therapy, which may improve medication adherence.

How to use ePA

You can request prior authorization for your patients with Cigna-administered coverage through your electronic health record (EHR) or electronic medical record (EMR) system or through one of the vendors listed below.

ePA vendor	EHR/EMR availability	Website availability	Questions
CoverMyMeds®	Yes	Yes, go to CoverMyMeds.com/epa/Cigna.	Call CoverMyMeds at 866.452.5017.
Surescripts®	Yes	No	Call Surescripts at 866.797.3239.

Please note that we are transitioning away from the PromptPA tool in 2020. If you currently use it for ePA, we encourage you to begin using CoverMyMeds or Surescripts or you may receive the following message: “Eligibility not found.”

If you are unable to use ePA, call 800.88Cigna (882.4462) to submit a prior authorization request.

Medications typically excluded from the prescription benefit

This information pertains to physicians and other providers

Cigna participants

Although health benefit plans vary, in general, a drug must be approved by the U.S. Food and Drug Administration (FDA), prescribed by a provider, purchased from a licensed pharmacy, and be medically necessary to be eligible for coverage. If the benefit plan provides coverage for certain preventive prescription drugs with no cost-share, covered employees may be required to use a pharmacy in network to fill the prescription. If employees use a pharmacy that is out of network, the prescription may not be covered. Certain drugs may require prior authorization or be subject to step therapy, quantity limits, or other utilization management requirements.

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of the specific plan:

- Over-the-counter (OTC) medications.
- Prescription drugs or supplies for which there is a nonprescription or OTC therapeutic alternative.
- Physician-administered injectable medications covered under the plan’s medical benefit, unless otherwise covered under the plan’s prescription drug list or authorized by Cigna.
- Implantable contraceptive devices covered under the plan’s medical benefit.
- Medications that are not medically necessary.
- Experimental or investigational medications, including FDA-approved drugs used for purposes other than those approved by the FDA (unless the drug is recognized for the treatment of the particular indication).
- Medications that are not approved by the FDA.
- Prescription and nonprescription devices, supplies, and appliances other than those supplies specifically listed as covered.

- Medications used for fertility, sexual dysfunction, cosmetic purposes, weight loss, smoking cessation, or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma, and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription drugs and related supplies due to loss or theft.
- Drugs that are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution that operates on its premises or allows a facility for dispensing pharmaceuticals to be operated on its premises.
- Prescriptions more than one year from the date of issue.

In addition to the plan's standard pharmacy exclusions, certain new FDA-approved drug products (including medications, medical supplies, or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless authorized by Cigna as medically necessary.

Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes precedence.

Compound medication coverage

A licensed pharmacist mixes compounded medications. The compounding pharmacist combines, mixes, or changes the ingredients to make a medication that may not be commercially available.

Compounded medications are generally made up of several different chemical ingredients. Cigna's pharmacy benefit plans only cover medications that are FDA-approved for safety and effectiveness. Ingredients that are not FDA-approved or not otherwise covered by the plan will not be reimbursed.

Cigna's home delivery

This information pertains to physicians and other providers

Cigna participants

Cigna provides a prescription drug home delivery pharmacy benefit designed for participants who take medication on a regular basis to help them manage chronic or long-term conditions. When participants use home delivery, they can get up to a 90-day supply of their medications. Benefits of the program are ePrescribing for providers, customer refill reminders and easy refills through myCigna.com and the myCigna app. The 90-day supply maximum is subject to physician judgment and U.S. Food and Drug Administration (FDA) dosage recommendations. In cases where a 90-day supply is not recommended by the FDA, prescribing physician, or Cigna, the home delivery quantity will be limited.

A generic equivalent drug is automatically substituted unless you indicate “dispense as written.”

According to a recent Cigna survey,* Cigna customers who fill 90-day prescriptions are more likely (by 41 percent) to adhere to them than those with 30-day prescriptions. Since adherence is such an important part of most health care plans, people who obtain 90-day prescriptions may experience improved health outcomes.

*Internal Cigna analysis performed January 2019, utilizing 2018 Cigna national book of business average medication adherence (customer adherent > 80% PDC), 90-day supply vs. those who received a 30-day supply taking antidiabetics, RAS antagonist and statins.

Cigna 90 Now

Cigna 90 Now provides customers with the option to fill their 90-day maintenance medication at one of over 31,000** retail pharmacies or through our home delivery pharmacy. Depending on their plan, they may also save money on 90-day prescriptions.

Two types of benefits**

- **Cigna 90 Now – Voluntary:** Customers have the option to fill their maintenance medication in either a 30- or 90-day supply but are encouraged to fill a 90-day supply.
- **Cigna 90 Now – Mandatory:** Customers are required to fill their maintenance medication in a 90-day supply. These medications are listed in the Cigna 90 Now Maintenance Drug List.

What this means to you

Customers with this specific benefit may contact you directly to discuss next steps or to request a new prescription written for a 90-day supply with refills. We strongly encourage you to consider writing 90-day prescriptions for maintenance medications for Cigna participants.

* Cigna 90 Now network as of July 2019. Subject to change.
** The Cigna 90 Now program does not apply to specialty medications or narcotics.

Pharmacy clinical support programs

Enhanced RxSavings Messenger

Enhanced RxSavings Messenger helps reduce medication costs for our customers and helps keep them on track to better health. This program enables providers to choose lower-cost, covered medications for their patients with Cigna-administered coverage.

For plans that have already received the claims engine upgrade as a result of our combination with Express Scripts, Enhanced RxSavings Messenger became available in June 2020. For all other plans, the program will be available as each plan receives the claims engine upgrade.

How the program works

We contact providers by electronic medical record, fax, or phone if they have a patient for whom they have prescribed a:

- Brand-name drug for which there is a generic equivalent, or
- Nonpreferred drug for which there is a lower-cost therapeutic alternative, or
- Drug that is not covered.

We will suggest a plan-preferred alternative drug, and the provider will determine whether it is appropriate for their patient.

If the provider authorizes an alternative drug, we'll send a follow-up confirmation letter, and the patient will receive a notification letter about the change. Both will include contact information to answer questions. If the patient uses Express Script Pharmacy, our home delivery pharmacy, we will dispense the medication upon receipt of the authorization.

Medication Safety program for narcotic medications

Cigna's Medication Safety program leverages a weekly retrospective review of pharmacy and medical claims data from the last 90 days to help identify individuals who have prescription patterns that may be indicative of fraud, substance use disorder, or an increased risk of an opioid-related medical emergency.

Our program analyzes medical diagnoses, prescription drug histories, and the number of physician, pharmacy, and emergency room visits over a specific time period and creates detailed profiles. These profiles help us identify individuals who may benefit from further discussion with their physicians about our findings. This discussion may result in an evaluation and/ or /plan of action.

Complex Psychiatric Case Management program

Cigna's Complex Psychiatric Case Management program provides physicians and psychiatrists with integrated support for their patients who are prescribed multiple psychotropic drugs. The program leverages Cigna Pharmacy Management® and Cigna Behavioral Health and supports patient care and the patient's adherence to their prescription drugs.

Cigna's Complex Psychiatric Case Management works in conjunction with Cigna Behavioral Health to optimize medication treatment regimens and decrease potential emergency room visits and mental health-related hospitalizations. The program uses six months of retrospective pharmacy and medical claims data to help identify individuals who fill prescription drugs in multiple therapeutic classes of psychotropic medications and multiple drugs within a specific class. This information is shared with providers to help optimize pharmacy, behavioral health, and medical benefit utilization.

Cigna Medication Coaching program

The Cigna Medication Coaching program is Cigna Pharmacy Management's outcome improvement program designed to help individuals stay adherent to their prescribed medications. The program includes a team of licensed Cigna pharmacists who are specialy trained and certified to help customers manage many conditions. Customers can talk with a pharmacist about medication options, ways to save money on their medications, barriers to medication adherence, side effects, and possible interactions.

Our pharmacists can also help facilitate a switch to our home delivery pharmacy. Customers can reach a Cigna pharmacist at 800.835.8981.

Specialty Pharmacy Prescription Drug program

For physicians and other providers only

In 2019, we transitioned Cigna customers to Accredo specialty pharmacy, a Cigna company. Accredo is the new national preferred source for specialty medications.

Accredo, a Cigna company, is in the pharmacy network for many of your patients with Cigna-administered plans. By using an in-network pharmacy, your patients with Cigna coverage will be able to take full advantage of their specialty drug coverage options.

What Accredo offers you and your patients

Through Accredo, you and your patients have access to a team of pharmacists and nurses with extensive training and experience. You'll be able to obtain specialty products, including many with limited or exclusive distribution, and your eligible patients will be able to obtain financial assistance coordination.

Specialty trained clinicians at Accredo Therapeutic Resource Centers[SM] utilize advanced skills and care management programs to:

- Emphasize patient empowerment strategies to improve adherence
- Support the healthcare provider/patient relationship and plan of care
- Ascertain whether disease-state signs and symptoms worsen, potentially warranting intervention
- Maintain open lines of communication with you and your patient

Services offered to Accredo patients include:

- Delivery to the place of administration
- Triage services
- Nutrition support
- Adherence checks
- Clinical counseling and support
- In-home nursing support

Ordering from Accredo

Designed to simplify administrative requirements for you and your office staff, Accredo makes ordering specialty pharmacy medications easy. When calling, faxing, or e-prescribing orders to Accredo, the pharmacy team will:

- Help collect necessary documentation
- Contact your patient or office to set up delivery
- Provide updates to your patients on order and shipment status through text, email, IVR or Accredo.com
- Notify you on patient refills and prior authorization requests by calling your office or via MyAccredoPatients.com. If you are currently not registered, follow the link and click and "register now."

Specialty Pharmacy Orders
Information on Accredo as well as medication-specific order forms can be found on Accredo.com > Prescribers > Referral Forms

Contact Accredo for specialty medication prescriptions and renewals as follows:

- Fax a completed specialty referral form to 888.302.1028
- Telephone specialty prescription orders to 866.759.1557
- E-prescribe to Accredo at NCPD ID: 4436920 – 1640 Century Center Parkway Memphis, TN 38134

If you have questions, contact the Accredo Physician Service Center at: 844.516.3319 or chat online via MyAccredoPatients.com.

Coverage for self-administered injectable medications
Some injectable medications are not covered under the Cigna medical plan but are covered under the Cigna Pharmacy Plan.

Some medical plans cover self-administered medications through the pharmacy plan vs. the medical plan. In order to be covered under the pharmacy plan, these medications must be obtained from either a retail pharmacy or Accredo, subject to the terms of the plan. If required, you may continue to administer these medications and you will be reimbursed for related administration costs. However, medical plans that have implemented this benefit change will no longer reimburse you for the cost of these medications. If a company other than Cigna provides your patient's pharmacy benefit, contact the pharmacy benefit company for information about coverage for these medications.

If you have questions about the coverage of a certain medication, contact Customer Service at the telephone number on the patient's ID card.

Cigna Specialty Pharmacy Management offers drug therapy management Cigna specialty condition counseling

For customers with complex conditions taking a specialty medication dispensed by Accredo, we offer **specialty medication and condition counseling** through Accredo's Therapeutic Resource Centers (800.351.3606). Customers taking a specialty medication not dispensed by Accredo will receive this important counseling from Cigna specialty condition counseling (800.633.6521).

Specialty Medical Injectables with Reimbursement Restriction (formerly Limited Distribution Drugs with Reimbursement Restriction)

Certain specialty medical injectables (SMI) must be dispensed and claims submitted by a specialty pharmacy with which Cigna has a reimbursement arrangement for the SMI in question. Cigna will no longer reimburse facilities that purchase these SMIs directly from specialty pharmacies, manufacturers or wholesalers and bill Cigna for the cost.

A facility shall not balance bill the participant for any amounts attributable to the cost of the SMI for which Cigna denies payment to the facility. Cigna shall, consistent with

Cigna's billing and reimbursement policies and procedures, reimburse facilities for any covered charges attributable to administration of the SMI.

If Cigna does not have a reimbursement arrangement with a specialty pharmacy that has access to the SMI at the time a participant seeks coverage and/or reimbursement, a facility may request an administrative exception to bill Cigna for the SMI. Any exception granted by Cigna shall be effective until Cigna establishes a reimbursement arrangement with a specialty pharmacy that has access to the SMI.

Cigna may also make exceptions to reimburse a one-time or single administration of a SMI billed by a facility under circumstances when a customer needs access to the SMI before arrangements can be made to obtain it from a specialty pharmacy with which Cigna has a reimbursement arrangement. For certain SMIs, the reimbursement restriction may apply when they are administered in a high-intensity setting, such as an outpatient hospital. This restriction does not apply to physicians who bill Cigna using their own physician fee schedules. The Specialty Medical Injectables with Reimbursement Restriction list only applies to facilities and physicians who bill Cigna using a hospital fee schedule.

The list of specialty medical injectables, which may change without prior notice, is available on the Cigna for Health Care Professionals website (CignaforHCP.com). To access the list of SMIs, please login to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Reimbursement Policies and Payment Policies> Precertification Policies > Specialty Medical Injectables with Reimbursement Restriction.)

Quality Management Program

The Quality Management Program provides direction and coordination of quality improvement and quality management activities across Cigna departments, including Utilization Management, Contracting and Provider Services, Customer Service, and Claims.

The Quality Management Program outlines processes for measuring quality and provides guidance in initiating process improvement initiatives when deficiencies are identified. Quality studies are designed and documented to evaluate the quality and appropriateness of care and service provided to participants. Program activities include:

- Review performance against the key quality indicators as identified in the quality work plan.
- Provide information about the quality and cost efficiency of participating providers and hospitals to facilitate more informed decision-making by the participants we serve.
- Evaluate participant and provider satisfaction information.
- Evaluate access to services provided by the plan and its contracted physicians and hospitals.

When an opportunity for improvement is identified through an evaluation of performance indicators or from other sources, Cigna uses a problem solving approach, the Continuous Quality Improvement (CQI) Process. If you would like more information about our Quality Management Program, including a more detailed description of the program and a report on the progress in meeting Cigna goals, please call 800.88Cigna (800.882.4462).

Cigna invites our contracted providers to actively participate in several of our quality committees, including the Clinical Advisory Committee, the Peer Review Committee, and the Credentialing Committee. Our commitment to quality is demonstrated through the program activities described below.

Clinical care guidelines

This information pertains to physicians and other providers

Clinical care guidelines, as outlined below, may be used as a resource as you screen and treat various conditions. Log in to the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Medical Resources > Case Management/Health and Wellness > Care Guidelines to view:

- **A Guide to Cigna's Preventive Benefits for Providers**
- **Clinical guidelines for behavioral health**, including depression, attention-deficit and hyperactivity disorder, and alcohol screening
- **Chronic condition management** (Cigna's Disease Management Program) adopted clinical practice guidelines from nationally recognized professional sources that provide evidence-based clinical support and background.

To view information on Chronic Condition Management, log in to the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Medical Resources > Commitment to Quality > Quality > Chronic Condition Management, or call 800.88Cigna (800.882.4462) to request a paper copy.

Peer review

This information pertains to physicians and other providers

Peer review is used to help uncover substandard or inappropriate care, or inappropriate professional behavior, by a practitioner. If the findings of the confidential peer review process indicate substandard or inappropriate participant care or inappropriate professional conduct, Cigna will take appropriate action. The actions that may be taken include development of a corrective action plan, education, counseling, monitoring, and trending of data, recredentialing within one year or less, notification to appropriate state and/or federal bodies, and limitation of or termination from participation. Peer review information is generally considered privileged and confidential under applicable state and federal laws.

Medical continuity and coordination of care

To facilitate continuous and appropriate care for participants, and to strengthen industry-wide continuity and coordination of care among providers, the quality program monitors, assesses, and identifies opportunities for providers to take action and improve upon continuity and coordination of care across health care settings and between providers as participants' conditions and care needs change during the course of treatment. Assessment of continuity and coordination of care is measured using valid data and analysis methodology and is conducted annually. Examples of monitoring may include:

- Coordination of care during care transitions in inpatient settings, such as hospitals, skilled nursing and hospice
- Coordination of care in outpatient settings, such as rehabilitation centers, emergency departments, and surgery centers
- Coordination of care when participants move between providers, such as specialist to primary care provider
- Notification and movement of participants from a terminated provider
- Monitoring of participants who qualify for continued coverage for services provided by a provider terminated for other than quality reasons

Examples of data that may be collected and measured by Cigna Quality Management staff to evaluate continuity and coordination of care are:

- Hospital readmissions
- Transitions from inpatient to nursing home or post-acute care settings
- Follow-up office visit post hospitalizations
- Adverse Event and Quality of Care Complaint monitoring data to identify trends or individual interventions which may be required

You can access tools that Cigna has developed to help facilitate communication between providers for exchanging clinical information by visiting CignaforHCP.com >

Resources > Medical Resources > Commitment to Quality > Quality > Continuity and Coordination of Care.

Continuity and coordination of care between medical care and behavioral health care

To facilitate continuity and coordination of care for participants among behavioral and medical practitioners and physicians, Cigna, in collaboration with our behavioral health partners, fosters and supports programs that monitor continuity and coordination of behavioral care through assessment of one or more of the following:

- Appropriate exchange of communication between behavioral and medical practitioners
- Appropriate provider screening/diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care
- Evaluation of the appropriate uses of psychotropic medications
- Management of treatment access and follow-up for participants with coexisting medical and behavioral health disorders
- Implementation of a primary or secondary behavioral health preventive program
- Address the special needs of participants with severe and persistent mental illness

Ambulatory Medical Record Review

This information pertains to physicians and other providers

As part of our Quality Improvement Program, and in select markets as required by state regulation, we review medical records from a random sample of participating primary care providers. The review assists in quality oversight, but does not define standards of care or replace the clinical judgment of treating physicians.

The objectives of the Ambulatory Medical Record Review (AMRR) are as follows:

- Determine the structural integrity and easy retrieval and access of medical records by authorized personnel
- Evaluate the adequacy of information necessary to provide appropriate care to participants
- Enhance patient safety by focusing on continuity and coordination of care
- Improve documentation of the clinical care delivered to Cigna participants

In addition, for those states that require it, providers are asked to attest to the adherence of confidentiality practices around secure storage of medical records and periodic training of staff in customer information confidentiality.

Medical records are randomly selected for review from physicians and for participants who have been enrolled in Cigna for a minimum of 12 months, and who have had a minimum of one visit within the last 12 months. Physicians receive a notification letter from Cigna when they are selected to participate in the review.

Physician scores are aggregated and analyzed at a market level. Indicators are individually trended. The goal is an aggregate score of at least 85 percent compliance among records reviewed. Study results and opportunities for improvement are reported

to the appropriate quality committee. Feedback of AMRR results and areas for improvement are shared with primary care providers and the Market Medical Executives.

For more information about AMRR, including assessment criteria and best practices, please visit the Cigna for Health Care Professionals website at CignaforHCP.com (Resources > Medical Resources > Commitment to Quality > Quality > Medical Record Reviews).

Pharmacy and therapeutics review

This information pertains to physicians and other providers

Cigna uses a Pharmacy and Therapeutics Committee (P&T). Committee participants include independent, actively practicing physicians and clinical pharmacists from across the United States. The committee meets six times per year to examine the safety and efficacy of new drugs and biologics as well as clinical updates to drugs and biologics previously reviewed by the committee.

The drug evaluation process employed by the P&T Committee is an evidence-based approach to clinical literature.

Through the P&T Committee evaluation process, drugs are determined to be clinically inferior, superior, or neutral to alternative therapies given data on safety and efficacy. The committee considers how well each drug works and potential side effects for the indicated treatment population, as well as identifies any subsets of the population with greater or less efficacy and/or safety. All approved drugs by the U.S. Food and Drug Administration (FDA) receive a determination of nonpreferred until a P&T Committee review can be held.

The P&T Committee will review all newly approved medications in an expeditious manner. To the extent possible, the P&T Committee attempts to review all new approvals and updates since their previous meeting. If a new medicine needs to be urgently reviewed, the committee is able to either host an ad hoc session or address via ballot vote. . The prescription drug list generally considers any generic drug to be preferred at the lowest tiers of a benefit plan. Preferred brand drugs are not necessarily clinically superior to alternative therapies and may be selected based on non-clinical factors such as cost.

Clinical and quality improvement studies

This information pertains to physicians and other providers

Clinical and quality improvement studies help evaluate quality and appropriateness of care provided to patients. Topics for evaluation and special studies are chosen based on relevant demographics and epidemiological characteristics of participants. Clinical studies review issues such as preventive care/HEDIS® measures against preventive care guidelines and compliance with treatment standards for depression. Scientifically based criteria are used for specific conditions, as developed by nationally recognized organizations and adopted by Cigna. Population-based assessment is conducted whenever appropriate, supplemented by focused medical record review and/or patient surveys. Data are collected, reviewed, and analyzed for trends and opportunities for improvement.

Physician and hospital performance evaluation

We evaluate the performance of contracted providers in 21 specialty types and acute care hospitals, in order to help provide Cigna customers with relevant information to make their own health care decisions. We may provide performance feedback to help you assess and enhance performance around quality of care and cost efficiency.

Such performance feedback may be based on surveys, review of medical records, and analysis of medical utilization. We are available to answer any questions you may have about this feedback. Components of this evaluation and information sharing are outlined below in the National Quality Initiatives section.

Information based on this evaluation is available in our provider directory and includes:

- Recognition for participation in National Quality Initiatives such as Leapfrog for Hospitals, the National Committee for Quality Assurance (NCQA) Recognitions for Physicians, and Bridges to Excellence (BTE) Provider Recognition
- Cigna Centers of Excellence
- Physician quality, cost-efficiency, and Cigna Care Designation information

Additional information detailing our methodology for provider and hospital evaluations can be found in the “National Quality Initiatives” sections that follow.

National quality initiatives

Individuals frequently ask us about participating hospital and physician involvement in national quality initiatives and the availability of information for quality comparisons of hospitals and physicians, including how this information is used. We encourage all participating hospitals and physicians to participate in national quality initiatives.

The Leapfrog Group Patient Safety Initiative

The Leapfrog Group is a not-for-profit organization committed to triggering giant leaps forward in the safety, quality and affordability of health care by:

- Supporting informed healthcare decisions by those who use and pay for health care
- Promoting high-value health care through incentives and rewards.

Cigna is a **Leapfrog Group Partner**. As a Partner, Cigna works collaboratively with Leapfrog and its Board of Directors to support their mission of promoting patient safety initiatives in the following ways:

- Participation in the Leapfrog Group’s Health Plan Users Group (HPUG). The HPUG brings together Leapfrog members and health plans to collaborate and develop patient safety goals and evaluation criteria metrics. Cigna completes and submits a Leapfrog HPUG Scorecard and a Performance Dashboard annually, and shares this information with employer and other clients
- Collaboration with regional employers and industry partners to help coordinate local efforts to advance Leapfrog’s mission.

  - The Leapfrog Group coordinates and supports its members' work on a national scale and important work is done by volunteers at the local level through Leapfrog Regional Leaders. Regional Leaders are local participants in markets where Leapfrog members work together to implement Leapfrog's goals. Leapfrog uses the Regional Leader strategy to integrate community-wide, multi-stakeholder collaboration into its national purchaser initiatives.

- Support of Leapfrog critical initiatives, such as the Leapfrog Hospital Survey and Hospital Safety Grade and Maternal/Child Safety.
- Cigna endorses and encourages hospitals to participate in the Leapfrog Hospital Survey through the Network News.
- Cigna incorporates the Leapfrog Hospital Safety Grade into the Hospital Quality Index for Centers of Excellence ratings, and makes information related to those network hospitals who participate in the survey publicly available.
- Participation and sponsorship of the Annual Leapfrog meetings and/or Awards Dinners.
- Participation in the Leapfrog Health Plan Group quarterly meetings.

Leapfrog works with its employer members to encourage transparency and easy access to health care safety information as well as to reward hospitals that have a proven record of high quality care. To learn more about the Leapfrog Group programs and initiatives, please visit http://www.leapfroggroup.org. The Leapfrog Hospital Survey and Hospital Safety Grade information is available on the Cigna provider directory, http://www.cigna.com/hcpdirectory/.

National Quality Forum

The National Quality Forum (NQF) was established to facilitate a national collaboration to improve health and health care quality through measurement. They strive to achieve this mission by convening key public- and private-sector leaders to establish national priorities and goals to achieve health care that is safe, effective, patient-centered, timely, efficient, and equitable. NQF-endorsed measures are considered the gold standard for healthcare quality measurement in the United States. Expert committees that are comprised of various stakeholders, including patients, providers, and payers, evaluate measures for NQF endorsement. The federal government and many private sector entities use NQF-endorsed measures above all others because of the rigor and consensus process behind them. We encourage all providers to become familiar with the endorsed measures to promote public accountability and quality improvement. Many of the measures are used in our evaluation process for hospitals and physicians. More information is available at www.qualityforum.org.

Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used. It is the lead

Federal agency charged with improving the safety and quality of America's health care system. AHRQ develops the knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions. More information is available at www.ahrq.gov.

National Committee for Quality Assurance Physician Recognition Programs

The National Committee for Quality Assurance (NCQA) is an independent nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. NCQA's voluntary Physician Recognition Programs recognize high-performing physicians and practices in key areas of clinical quality and care coordination. NCQA acknowledgment in our online directory is given to physicians who have received recognition in any of these four NCQA Physician Recognition Programs:

- NCQA Diabetes Recognition Program (DRP)
- NCQA Heart/Stroke Recognition Program (HSRP)
- NCQA Patient-Centered Medical Home Recognition (PCMH - 2 versions)
- NCQA Patient Centered Specialty Practice Recognition (PCSP)

Additional information about these programs is available on the NCQA website (NCQA.org > Programs > Recognition).

Bridges to Excellence Provider Recognition

Bridges to Excellence (BTE) programs measure the quality of care delivered in provider practices. BTE emphasizes managing patients with chronic conditions, who may be at risk for potentially avoidable complications. We identify providers in our online provider directory who have received recognition in any of these BTE programs. BTE is currently available for these health concerns:

- Asthma care
- Cardiac care
- Chronic obstructive pulmonary disease (COPD) care
- Depression care
- Diabetes care
- Heart failure care
- Hypertension care
- Inflammatory bowel disease (IBD) care
- Maternity care

Additional information about these programs is available on the BTE website (BridgestoExcellence.org).

Quality, cost-efficiency, and Cigna Care Designation displays

To help provide Cigna customers with relevant information to help them make their own health care decisions, we evaluate quality and cost-efficiency information by using a methodology consistent with national standards and incorporating physician feedback for contracted providers in 21 specialty types. Physicians who meet Cigna's specific quality and cost-efficiency criteria can receive the Cigna Care Designation (CCD).

Quality and CCD displays are available on both the public and secure websites at Cigna.com and myCigna.com. Cost efficiency displays are available only to customers via the online provider directory on the password-protected website, myCigna.com.

Quality evaluation and displays are determined based on:

1. Group board certification
2. Adherence to evidence-based medicine clinical measures
3. National Committee for Quality Assurance (NCQA) Physician Recognition
4. Bridges to Excellence (BTE) Provider Recognition

For cost evaluation and displays, we use OptumInsight™ Episode Treatment Group (ETG®) methodology, an industry standard, to evaluate the cost-efficiency of individual physicians and groups. The methodology incorporates case-mix and severity adjustments, using algorithm logic to cluster claims paid into over 500 different episodes of care.

Additional information about the Optus Insight Episode Treatment Groups, including a complete listing of the ETGs, is available on the Optus website ETG Transparency Learning Community home page (https://learning.optum.com/exp/etg_transparency/page/home).

Stars are used to communicate cost-efficiency performance based on Cigna's measures. One, two, or three stars are assigned to providers to illustrate cost-efficiency. Three stars represents the top 34%, two stars represents groups in the middle 33%, and one star represents groups in the bottom 33% for cost-efficiency.

Physicians, who meet our specific quality and cost-efficiency criteria, can receive the Cigna Care Designation for a given specialty and will receive the  symbol next to their name in our online provider directory tools. CCD information may also be utilized as part of a tiered benefit plan option. Additional information on Cigna products and benefit plans is available on the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Medical Resources > Medical Plans and Products).

How providers are evaluated for Cigna Care Designation

Cigna evaluates whether the physician or group has achieved certain quality and cost-efficiency results, which are described more fully below. If the physician or group achieves those results, then the physician or group may be assigned the Cigna Care Designation. A full description of the methods we use to determine provider quality, cost efficiency and CCD results is available at Cigna.com/CignaCareDesignation. Participating physicians may receive Cigna Care Designation if the physician or physician group:

- Is located in one of the 74 markets that currently participate in this program
- Practices in one of the 21 assessed specialties
- Meets Cigna group board certification criteria
- Has a minimum volume of 30 complete (ETG) occurrences **AND**

- Group performance in the top 34 percent for quality OR have 50 percent of provider in the practice achieve NCQA or BTE recognition **AND** meet the cost-efficiency criteria of being in the top 34 percent **with** the groups Adjusted Performance Index (API) less than or equal to 1.03 **OR**
- Group performance in the top 25 percent for quality **OR** have 50 percent of provider in the practice achieve NCQA or BTE recognition **AND** have less than 30 ETG® episodes (with no cost ranking) **OR**
- Group performs in the top 25 percent for cost **with** the groups API less than or equal to 1.03 **AND** are either between 2.5 and 66 percent for quality or have less than 30 EBM opportunities (with no quality ranking).

We inform our customers that quality, cost efficiency and CCD displays should not be the sole basis for their decision-making because our review for cost-efficiency and quality reflects only a partial assessment of cost-efficiency and quality. There could be a risk of error in the data used to perform the review, and inclusion of a physician as CCD does not mean that the physician offers equal or greater quality and cost efficiency than other participating providers. We encourage customers to consider all relevant factors when choosing a primary care physician or specialist for their care, and to speak with their treating physician when selecting a specialist.

Requests for reconsideration or additional information
Participating physicians and physician groups have a right to seek correction of errors and request data review for their quality and cost-efficiency displays.

To request additional quality and cost-efficiency information, detailed reports, request a reconsideration, correct inaccuracies, submit additional information or obtain a full description of the methodology, email us at PhysicianEvaluationInformationRequest@Cigna.com or fax requests to 866.448.5506. Please include your or your practice's name, tax identification number, city, state, and ZIP code.

A full description of our reconsideration process is available on the Cigna website at Cigna.com/cignacaredesignation.

Centers of Excellence
The Centers of Excellence acute care hospital program was developed to help provide Cigna customers with relevant information to make their own health care decisions. The profiles contain information for up to 18 inpatient surgical procedures and medical conditions, 14 of which contribute to seven categories that combine related procedures, and are available for most Cigna-participating hospitals. A score of up to three stars (*) each for both patient outcomes and cost-efficiency measures can be received for each procedure and condition evaluated. Hospitals that attain either six or five stars (three stars for patient outcomes plus two stars for cost-efficiency OR three stars for cost-efficiency plus two stars for patient outcomes) receive the Cigna Center of Excellence designation for that procedure or condition. The data used to profile these procedures and medical conditions is derived from publically available, hospital self-reported All-Payer and MedPAR data. (We used MedPAR data when All-Payer data was not available.) We used two years of hospital data in the analysis.

To learn more about Cigna's Centers of Excellence program, please access Cigna's Centers of Excellence Methodology white paper on the Cigna for Health Care Professionals website (CignaforHCP.com).

Additional details about our methodology can be found at Cigna.com/CentersOfExcellence. If you have further questions, please call 800.88Cigna (800.882.4462).

Cigna bariatric center designations
Cigna has two bariatric center designations - a 3 Star Quality designation and the Center of Excellence (COE) designation.

3 Star Quality Bariatric Center program requirements

- Active status with Cigna as a participating bariatric treatment center
- A Bariatric treatment facility must be Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accredited in either Comprehensive or Comprehensive with Adolescent accreditation types.

Cigna Bariatric Center of Excellence designation requirements

- Active status with Cigna as a participating bariatric treatment center
- A Bariatric treatment facility must be Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accredited in either Comprehensive or Comprehensive with Adolescent accreditation types
- Receive two or three stars for cost-efficiency
- Minimum volume criteria to be evaluated for cost efficiency is at least 50 inpatient bariatric procedures during the assessment period.

Designated bariatric treatment facilities are identified in our online directory on Cigna.com and myCigna.com.

About the MBSAQIP
The MBSAQIP works to advance safe, high-quality care for bariatric surgical patients through the accreditation of bariatric surgical centers. Accreditation is achieved following a rigorous review process during which a center proves that it can maintain certain physical resources, human resources, and standards of practice. All accredited centers report their outcomes to the MBSAQIP database.
For more information, visit CignaforHCP.com > Resources> Medical Resources> Commitment to Quality > Cigna Centers of Excellence Program Methodology.

Preventive care

Cigna's preventive care coverage complies with the Affordable Care Act (ACA). Services designated as preventive care include periodic well visits, routine immunizations and certain designated screenings for symptom-free or disease-free participants. They also include designated services for individuals at increased risk for a particular disease.

The ACA requires health plans to cover preventive care services with no patient cost sharing, unless the plan qualifies under the grandfather provision or for an exemption. The majority of Cigna plans fall under the ACA, and cover the full cost of preventive care services, including copay and coinsurance. Typically, in-network providers must provide these services. There are some exceptions.

To determine whether or not your patient's Cigna administered plan covers preventive care and at what coverage level (100% or patient cost share), visit the Cigna for Health Care Professionals website (CignaforHCP.com) to verify benefit and eligibility information, or call 800.88Cigna (882.4462).

Preventive care services
The ACA has designated specific resources that identify the preventive services required for coverage by the Act:

- U.S. Preventive Services Task Force (USPSTF) A and B recommendations
- Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); recommendations of the ACIP appear in three immunization schedules
- Comprehensive Guidelines supported by the Health Resources and Services Administration (HRSA):
    - Guidelines for infants, children, and adolescents appear in two charts: the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children
    - Guidelines specifically issued for women

Coding for preventive services
Correctly coding preventive care services is essential for receiving accurate payment. Submit the preventive care services with an ICD-10 code that represents health services encounters that are not for the treatment of illness or injury.

- Place the ICD-10 code in the first diagnosis position of the claim form.
- Preventive care service claims submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim will be paid as applicable under normal medical benefits rather than preventive care coverage.
- Non-preventive care services incorrectly coded as "Preventive Medicine Evaluation and Management Services" will not be covered as preventive care.

Modifier 33: Preventive service modifier

- Cigna claim systems are not configured to process preventive service claims solely based on the presence of modifier 33, which was developed by the industry in response to the ACA's preventive service requirements. Preventive care services are dependent upon claim submissions using preventive diagnosis and procedure codes in order to be properly identified and covered as preventive care services.

For additional information about preventive health coverage, refer to Administrative Policy A004 Preventive Care Services available on the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Payment and Reimbursement Policies).

Gaps in Care: A comprehensive program to help improve wellness

Cigna has comprehensive gaps in care program that includes RationalMed® for Cigna and Well Informed. Using these two solutions together, we can identify additional risks, potential adverse events, and care improvement opportunities to help drive improved wellness for your patients with Cigna-administered coverage. Both programs use medical, pharmacy, and laboratory data to identify potential gaps in care.

Customers with chronic illnesses and acute conditions will benefit because we may be able to identify even more opportunities for them to improve their health. As their provider, you'll benefit because you can consider these expanded findings when making decisions about your patient's treatment plan. The goal is to support your efforts and help your patients make better health decisions, as well as prevent unnecessary and costly hospitalizations.

About Well Informed

This program helps us identify disease prevention and improvement opportunities by addressing potential gaps in care, which may include the following:

- Medication adherence.
- Patient safety.
- Achievement of key clinical targets.
- Monitoring.
- Appropriate therapy or drug.

We notify both you and your affected patients of any identified gaps and provide personalized instructions to help reduce and close them.

About RationalMed for Cigna

Express Scripts administers RationalMed for Cigna. This program complements Well Informed by helping us identify additional risk-reduction opportunities related to potential gaps in care, such as the following:

- Adverse drug disease consideration.
- Adverse drug interaction.
- Dose duration consideration.
- Drug-Patient age consideration.
- Drug pregnancy consideration.
- Drug therapy duplication.
- Duration consideration.
- Excessive dosing.
- High-risk medications.
- Pharmacogenomics.
- Quantity considerations.
- Misuse/abuse.
- Polypharmacy.
- Under dosing.

When we identify these additional gaps, we'll provide you with timely, actionable data to help you decide whether any changes in therapy are necessary. Note that we will not send information to patients.

We'll send RationalMed for Cigna messages through your electronic medical record or by letter or fax. Prescribing pharmacists will also receive alerts to help ensure care is

coordinated across your patient's health care team. Note that the alerts will have a different look and feel than those we send for the Well Informed program. In addition, the phone number listed will connect providers and pharmacists with the Express Scripts team, which exclusively handles calls about RationalMed for Cigna.

Additional information

For more information about these programs, please go to the Cigna for Health Care Professionals website (CignaforHCP.com) > Get questions answered: Resource > Medical Resources > Case Management / Health and Wellness: View Documents > Gaps in Care Programs.

Cigna Telehealth Connection

With Cigna Telehealth Connection, employees can get the care they need – including most prescriptions – for a wide range of minor conditions. They can connect with a board-certified doctor when, where and how it works best for them – via video or phone – without having to leave home or work.

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: Amwell or MDLIVE doctors.

Amwell and MDLIVE televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit with a primary care provider. Giving employees an easy-to-use and cost effective alternative to care can help reduce costs and non-urgent ER visits.

Cigna's 24-Hour Health Information Line℠

The majority of Cigna's medical plan participants have access to our 24-Hour Health Information Line. This service provides convenient, toll-free access to medical information and assistance any time of the day or night. This service is provided at no additional cost to participants and includes the following features:

- Access to nurses who provide education and support to empower customers with the relevant information to assist them with their health care decisions
- General health information on a wide variety of topics, such as preventive care, illness and condition definitions, diagnostic tools, and surgical procedures
- Level of care setting decision-support (e.g., emergency room, urgent care, physician's office or home, and self-care)
- Access to an audio library on hundreds of topics; information can also be accessed online
- Assistance in locating contracted physicians, hospitals, ancillaries or other providers, even when outside the normal service area

Participants should call the phone number on the back of their ID card and ask to be connected to the 24-Hour Health Information Line.

Maternity programs

Cigna provides several maternity-related services for your patients who are pregnant or plan to become pregnant. We encourage you to refer your patients to these programs and services.

Cigna Healthy Pregnancies, HealthBabies® Program

Cigna Healthy Pregnancies, Healthy Babies is a collection of maternity benefits for expectant parents and an educational mailing/maternity kit, offered as part of the Cigna medical benefit plan at no additional cost to members. The mailed workbook includes topics for soon-to-be moms such as prenatal care, exercise, stress, and depression. It also includes a list of web resources, a list of pregnancy-related topics in the 24-hour Health Information Line audio library, and a journal for the expectant mom to help her track her pregnancy. Members contact Cigna to receive their educational mailing and workbook. Kits are available in English and Spanish.

Participants have around-the-clock access and support through Cigna's 24-Hour Health Information Line.

The program also helps participants identify risk factors associated with their pregnancies, and provides access to specialized case management intervention when appropriate.

High-risk maternity case management

Our high-risk maternity case management program is available to the majority of Cigna medical plan enrollees at no additional cost. High-risk maternity case management is focused on providing support for women who have been identified as being potentially at risk for pregnancy-related complications and prenatal hospitalizations because of co-morbid medical conditions. Our high-risk maternity case managers are trained and experienced former obstetrical nurses. They have condition-specific case management tools available to them to provide guidance in assessment, intervention, and documentation of key interventions to help close any possible gaps in care and support you in caring for these women. When women are hospitalized for non-delivery maternity admissions, these high-risk maternity case managers assume the responsibility of inpatient case management (concurrent review), discharge planning, and post-discharge outreach and follow-up. Our high-risk maternity case management program integrates with other Cigna programs as needs are identified, such as Cigna's behavioral health and EAP programs to provide additional support and information.

Healthy Pregnancies, Healthy Babies®: Cigna's maternity program

The Cigna Healthy Pregnancies, Healthy Babies maternity program is available to women enrolled in some of Cigna's health plans. This program is a self-referral program for all pregnant participants, regardless of risk. This comprehensive program was created to help improve newborn outcomes. Specific clinical goals are to decrease the preterm (less than 37 weeks) delivery rate and decrease the low birth weight (less than 2,500 grams) newborn rates. This is accomplished through the following initiatives:

- Preconception planning and education
- Infertility education and shared decision-making tools, and guidance to an identified infertility Center of Excellence

- Increased identification rates
- Increased program completion rates
- Assessment of every identified pregnant participant early upon enrollment to identify risk level and apply appropriate interventions, including early enrollment in the specialty high-risk maternity case management program, when applicable
- Collaboration with treating providers
- Development of care management plans tailored to each woman's specific needs
- Ongoing reassessment and re-stratification (if applicable) of participants to manage developing risks
- Delivery of improved education and tools for self-care
- Reduction of modifiable pregnancy risks through nutrition, exercise, smoking and alcohol cessation, and periodontal disease education
- Appropriate follow-up to support the management plan

The program was designed to maximize participation using financial incentives to participants upon completion of the program, although not all employers offer incentives. Once enrolled, a Cigna maternity specialist conducts a specialized screening to stratify the pregnant woman according to risk level (minimal, moderate, high), which guides the level of outreach required. At a minimum, there are scheduled calls throughout the pregnancy and two postpartum calls. Outreach includes a broad assessment of newborn- and maternity-related issues; education on newborn care and postsurgical care (if applicable) and a wide range of maternity-related topics; and an assessment of postpartum depression/stress, with referrals to the appropriate behavioral provider as needed.

All program participants receive a Healthy Pregnancies, Healthy Babies educational workbook upon enrollment. The workbook is filled with pages of useful information, tips, and resources to help members through their pregnancies and after they give birth.

The program now includes the Healthy Pregnancy App, which integrates program information and resources to deliver convenient, personalized guidance to help expectant mothers manage their health and wellness. The app also connects to other available services, such as Health Alerts and Reminders, Find a Doctor cost and quality tools, health coaching programs, and incentive programs.

Oncology programs

Oncology case management

Our oncology case management program is available to the majority of Cigna medical plan enrollees at no additional cost, and focuses on improving the quality of care and life for participants with cancer. Specialty case managers work with participants, their doctors, and their families to help ensure that the participants are informed and involved in treatment decisions, and that they are compliant with those decisions.

Part of the overall goal is to reduce avoidable hospitalizations and emergency room visits due to complications from chemotherapy and inadequate symptom management.

Working with a Cigna oncology case management nurse is encouraged for participants who are in active treatment, such as chemotherapy and radiation therapy, with or without

complications. Nurses support individuals through the case management process of assessment, planning, goal setting, facilitation, and advocacy support for the individual's unique health needs.

Participants with a cancer diagnosis are primarily identified through prior authorization, claims data, health assessment responses, outside referral sources, and laboratory results as well as inpatient hospitalizations. Additionally, the program integrates with our medical management programs (utilization management and case management), the organ and stem cell transplant program, our chronic condition management program, and behavioral health programs. This coordination helps facilitate referrals between programs and the appropriate exchange of information.

Cigna's oncology case managers, who are trained nurses, have clinical expertise and competencies, and are supported by Cigna's oncology physicians with expertise in caring for individuals and families with cancer.

Our Cigna oncology case managers assist participants in the following ways:

- Help participants navigate the complex health care system and minimize the administrative hassles of claim payment, benefit, and authorization issues.
- Provide a holistic based biopsychosocial assessment to help identify needs that may interfere with optimal outcomes and identification of gaps in care. Through this identification, Cigna's oncology case managers provide information, resources and make internal program referrals to address the holistic needs of the individual with cancer.
- Provide information, educational tools, and resources about the condition treatment options and services available to participants and their families.
- Help participants learn how to cope with changes to everyday life.
- Provide early intervention and support of the customer and family in understanding the condition, available treatment options, and evidence-based care.
- Educate participants about potential treatment side effects, and how they can respond to minimize side-effect impact.
- Anticipate and plan for potential care needs to help minimize avoidable disruptions and delays in accessing care.
- Help individuals find quality care through Cigna's network or participating providers including Cigna's Collaborative Care partnerships to help deliver evidenced-based standards that can improve quality, cost-effectiveness and customer satisfaction, and providing direct links to national cancer sites, such as the National Cancer Institute, the National Comprehensive Care Network (NCCN), and WebMD® Cancer Information Center.
- Work with Cigna's oncology physicians who provide clinical support for utilization review and oncology case management.
- Coordinate with a behaviorist and pharmacist to support multiple-disciplinary clinical rounds.
- Act as liaison between physician and plan participant and family.

When appropriate, the end-of-life component of our program focuses on supporting participants and their families as they transition to hospice or palliative care. Case

managers can provide emotional and clinical support to participants and their families in planning end-of-life care.

Cigna Cancer Support
Cigna Cancer Support, our robust oncology program, is available to participants enrolled in some of Cigna's health plans. This program offers assistance and care support for the entire experience from diagnosis to treatment to remission. The goals of the program are improved quality of life and reduced clinical and economic adverse consequences. Through proactive contact, screening, education, and assistance for participants with cancer diagnoses, we use Cigna's expertise and resources to support the participant to recognize risk regardless of where the participant is in his or her cancer journey.

All types of cancers are included in the program, except for non-melanoma skin cancer and "in situ" cancers that are readily resolved through removal.

Participants with a cancer diagnosis are primarily identified through claims data, health assessment responses, outside referral sources, and laboratory results. Additionally, the program integrates with our medical management programs (utilization management and case management), the organ and stem cell transplant program, our chronic condition management program, and behavioral health programs. This coordination helps facilitate referrals between programs and the appropriate exchange of information.

Our case managers are nurses who have oncology expertise and competencies, and are part of a dedicated, centralized team.

Cancer Support nurses work with participants at various levels of acuity (stratification) offering support to cancer survivors and those who have had cancer in the past who still take medications or have some kind of ongoing preventative treatment for cancer. These nurses can assist participants in the following ways:

- Help participants navigate the complex health care system and minimize the administrative hassles of claim payment, benefit, and authorization issues.
- Assist participants to understand advancement and treatment in cancer care such as new testing and medications
- Provide a holistic based biopsychosocial assessment to identify needs that may interfere with optimal outcomes and identification of gaps in care. Through this identification, Cigna's oncology case managers provide information, resources and make internal program referrals to address the holistic needs of the individual with cancer.
- Provide information, educational tools, and resources about the condition treatment options and services available to participants and their families.
- Help participants learn how to cope with changes to everyday life.
- Provide early intervention and support of the customer and family in understanding the condition, available treatment options, and evidence-based care.
- Educate participants about potential treatment side effects, and how they can respond to minimize side-effect impact.
- Anticipate and plan for potential care needs to help minimize avoidable disruptions and delays in accessing care.

- Help individuals find quality care through Cigna's network of participating providers including Cigna's Collaborative Care partnerships, to help deliver evidenced-based standards that can improve quality, cost-effectiveness and participant satisfaction, and providing direct links to national cancer sites, such as the National Cancer Institute, the National Comprehensive Care Network (NCCN), and WebMD® Cancer Information Center.
- Work with a Cigna's oncology physicians to provide clinical support for utilization review and oncology case management.
- Coordinate with a behaviorist and pharmacist to support multiple-disciplinary clinical rounds.
- Act as liaison between physician and customer and family.

When appropriate, the end-of-life component of our program focuses on supporting participants and their families as they transition to hospice or palliative care. Case managers can provide emotional and clinical support to participants and their families in planning end-of-life care.

The program also includes benefits and other resources for financial and care support.

Chronic condition management

Our whole-person solution weaves all the health issues affecting a participant with one or more chronic conditions into one ongoing conversation. Cigna's chronic condition management solution provides health management coaching tailored to each participant’s preferences. Moreover, it is all delivered through the continuous, personalized support of a dedicated health advocate. These advocates:

- Support participants with their physician-recommended treatment and symptom management plans
- Empower participants to take actions regarding opportunity of care to help mitigate negative health consequences
- Collaborate in the development of individual action plans to assist the participant in reaching their healthy lifestyle goals

The primary goal of the program is to help participants improve the quality of their lives and overall health. Cigna’s chronic condition management program is a primary advocate model; once a participant and health advocate relationship is formed, the health advocate remains that participant’s health advocate for future needs or concerns, whenever possible.

To identify plan participants who may benefit from chronic condition coaching, we leverage multiple data sources to help identify potential candidates. We also identify potential program participants through provider, medical management, pharmacy, and other health advocacy program referrals, as well as individual self-referrals. A single, proprietary analytic tool integrates the relevant information we know about a customer to identify and initially segment each person with a chronic condition into one of two segments: telephonically coached or self-guided online. We identify and outreach to program candidates to encourage participation in coaching or enrollment in an online program. Participants who enroll in an online program also have access to a health advocate.

Outreach is triggered by the following chronic conditions:

Asthma	Heart disease	Coronary artery disease
Angina	Congestive heart failure	Acute myocardial infarction
Bipolar disorder	Diabetes, type 1	Diabetes, type 2
Depression	Peripheral arterial disease (PAD)	Low back pain
Metabolic syndrome; weight complications	Chronic obstructive pulmonary disease (emphysema and chronic bronchitis)	Anxiety
Osteoarthritis		

Integration of participant information, used to determine key clinical targets, aligns resources to the participant's needs. Cigna's dynamic process of ongoing assessment and segmentation gives health advocates the ability to assist participants in addressing their needs, helping to avoid potential risks.

Supported by evidence-based clinical guidelines and influential behavioral techniques, our health advocates help program participants manage many aspects of their personal health. This includes adherence to medications, understanding and managing risk factors, maintaining up-to-date screenings, participating in monitoring tests, treatment decision support, pre- and post-hospitalization outreach, lifestyle management coaching, and more.

From a provider's perspective, the Cigna team is a resource to help facilitate compliance with the treatment plan that has been created to manage their chronic conditions and health risks as well as to help prevent complications. Our goal is to educate patients about their health, support them in their relationship with you, and empower them to become active participants in their own health care. We support the patient-provider relationship by helping to prepare participants to have meaningful and educated interactions with their treating providers and other members of their health care team.

To view information on our chronic condition management program, log in to the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Medical Resources > Case Management/Health and Wellness > Case Management & health Engagement Programs > Chronic Condition Management.

Information provided includes:

- Detailed program description and supporting program materials with reference to how we identify, stratify, and engage potential chronic condition participants
- An overview of clinical resources used by coaches
- The evidence-based guidelines used for each program
- Provider rights when working with Cigna and our programs
- Details of how the chronic condition program integrates with behavioral health
- Opportunity care outreach, including timelines

- Samples of communications provided to customers and providers
- Hours of operation and contact information, including telephone number

Cigna's health advocacy programs

Cigna defines “health advocacy” as proactive, personalized, and integrated health support and coaching that helps drive participant engagement and healthy behavior change across a population. Cigna is committed to helping the people we serve identify and address health risks and behaviors that, when addressed, can help prevent or reverse disease. The following provides high-level summaries of some of these programs.

Please note that some clients select health advocacy models that combine the standard medical management services with chronic condition support and some or all of our optional health advocacy programs.

Health assessment and online coaching programs

All Cigna participants have free online access to health assessments. Through their health assessment responses and the supporting Trend Management System (TMS), with its application of sophisticated underlying analytics, we can help people recognize and address potential health risks. Participants receive feedback that can help them identify health issues they can address. The health assessment process also evaluates each participant’s health assessment responses to help identify those who may benefit from enrollment in various health coaching programs that address, for example, health and wellness topics, lifestyle management issues, or chronic conditions.

My Health Assistant is a suite of online coaching programs built on the concept of small steps leading to larger changes over time. They can deliver a robust and personalized experience. Participants select the health goal or goals they would like to tackle, choose activities to incorporate into their plan, and check in regularly to record their successes. My Health Assistant online coaching programs are integrated with our health coaching programs, allowing us to incorporate these programs in our whole-person coaching approach and enabling additional options for participants who prefer to engage in online coaching. Topics include general health and wellness, lifestyle management, and specific chronic condition goals.

Cigna Diabetes Prevention Program in Collaboration with Omada

Cigna’s Diabetes Prevention Program in Collaboration with Omada is a digital lifestyle change program designed to help individuals lose weight, gain energy, and reduce the risks of type 2 diabetes and heart disease. The program surrounds participants with the tools and support they need to make lasting, meaningful changes to the way they eat, move, sleep, and manage stress—one small step at a time. The program is available at no additional cost for covered individuals over the age of 18 that are enrolled in the company medical plan offered through Cigna, are at risk for type 2 diabetes or heart disease, and are accepted into the program.

Patients may call the telephone number on their Cigna ID card to determine if this program is available to them.

Cigna's Health Advisor® coaching program

Some Cigna clients include our Health Advisor program as part of their employees' benefit package.

As with all of our health advocacy programs, the goal of the Health Advisor program is to help the people we serve improve their health, well-being, and sense of security. The program focuses on engaging at-risk participants in topics related to wellness and prevention and is designed to facilitate healthy behaviors and promote the achievement of health-related goals.

Using health assessment responses, as well as input from other data sources, such as claims, lab, and biometric results, the program provides an integrated look at a participant's risk for any of five health and wellness topics in order to assess the benefits of targeted outreach and intervention. The five topic areas are hypertension, hyperlipidemia, physical activity, pre-diabetes, and healthy eating.

The Health Advisor health advocates also provide preference-sensitive coaching (treatment decision support) for seven conditions: back pain, coronary artery disease revascularization, benign uterine conditions, osteoarthritis of the hip (joint replacement), osteoarthritis of the knee (joint replacement), breast cancer, and prostate cancer. The health advocates discuss viable treatment options and help participants identify their own preferences and values as part of the decision-making process. They also guide participants to online resources, including treatment decision support web modules. By using these tools and participating in coaching, your patients work through decision paths that describe the benefits and risks of each treatment option. This helps your patients organize questions and points of discussion to review with you as you work together to come to a treatment decision.

Health advocates also review gaps in care data to coach participants for whom a potential gap in care has been identified, and for whom coaching may be appropriate.

Patients may call the telephone number on their Cigna ID card to determine if this program is available to them.

Lifestyle management programs

Cigna offers three lifestyle management programs built around telephonic or face-to-face communication sessions with a health advocate, and an online model that offers secure, convenient information for participants who prefer a less personal interaction. Health advocates use a motivational interviewing style, which holds participants responsible for choosing and carrying out actions to change. These one-on-one sessions, along with supplemental educational materials and interactive tools, help support participants in their focus on changing old habits into new, healthier ways of life.

Programs include:

Weight management

Our weight management program is designed to provide a structured approach and a motivational support system to help participants more effectively manage weight. Participants follow a non-diet program, including a healthy living plan, to achieve long-term lifestyle behavior changes.

Stress management
Our stress management program is designed to provide a structured approach and motivational support system to help participants more effectively manage their stress, both on and off the job. The program focuses on changing behavior and habits, enabling participants to create their own healthy living plans.

Tobacco cessation
Our tobacco cessation program helps participants weigh the benefits of quitting, understand their personal triggers, cope with withdrawal symptoms, and create positive habits to stay tobacco-free.

Patients can call the telephone number on their Cigna ID card to determine if this program is available to them.

Integrated health advocacy programs
To meet the requests of some of our clients, and to provide the benefits of integrated services to the participants we serve, Cigna has combined components of multiple programs into integrated solutions.

Personal Health Team
Personal Health Team (PHT) staff, including teams of nurses, health educators, and other specialists, form client-designated teams to provide core/complex case management and certain client-selected health coaching programs to these client populations. With a focus on preventing avoidable readmissions, the case management services include pre-admission and post-discharge outreach to hospitalized participants in order to provide health related information, help set discharge expectations, support the physician's treatment plan, problem solve to remove barriers to compliance with the treatment plan, and encourage participation in any other available and appropriate Cigna support programs.

In addition to their choice of included core medical management programs, these Cigna clients may elect to include coaching programs that address chronic conditions, lifestyle management issues for weight, stress, and tobacco use, and various health and wellness topics.

Healthcare Effectiveness Data and Information Set

This information pertains to physicians and other health care providers.

Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to improving health care quality. HEDIS is designed to provide purchasers and consumers the information they need to reliably compare the performance of health plans. HEDIS also includes the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a standardized survey of consumer experiences that evaluates plan performance in areas such as customer service, access to care, and claims processing. Individual HEDIS measures may also be used to evaluate the efficacy of health management systems, the impact of practice guidelines, and adherence to preventive health recommendations.

Cigna annually compiles preventive and chronic health data according to HEDIS guidelines and specifications. HEDIS data is obtained from three sources: administrative data, supplemental data, and medical records. Administrative system data is derived from claim and encounter data. Supplemental data (e.g., EHR data, immunization registry data, etc.) is obtained outside of the claims delivery process and is used to fill gaps in services. For some measures, medical records must be collected annually between January and May. The purpose for record collection is to validate accurate and comprehensive care provided by health care professionals.

The HEDIS data collection process is dependent on the cooperation and assistance of Cigna's network of physicians and providers. The following is a highlight of the medical record process:

- Cigna requests medical records from providers for customers chosen through a randomized sample selection process and identified through claims and eligibility data.
- HEDIS medical record requests are sent beginning in late January each year. The request includes a list of customers and the specific information required to meet the HEDIS specifications.
- HEDIS-related medical record information should be returned to Cigna within 30 days of the request. Electronic medical record submission is the safest and most efficient way to transmit your documentation. It also provides the least amount of disruption to your office. We are able to remotely access medical records through our secure network, or you can upload the requested medical records to our secure file transfer protocol (SFTP) site.
- For providers who use copy service vendors, it is the provider's responsibility to ensure that the copy service vendors submit requested records to Cigna by the due date in the request and not later than April 15. Follow-up requests to the providers will occur for vendors who do not comply with HIPAA requirements, return incomplete records, or do not return records within the requested timeframe.

  Note: Failure of a provider or provider's contracted copy service vendor to cooperate with the HEDIS data collection process is considered a breach under the terms of Cigna participation agreements and may be grounds for termination from Cigna network participation.

Your participation agreement provides for the release of medical record information to Cigna for these quality projects without specific patient permission. If you have any questions or concerns, please review the guidelines on the HIPAA website at cms.hhs.gov.

*HEDIS® is a registered trademark of NCQA

HEDIS® medical record review

This information pertains to physicians and other health care providers

A comprehensive list of medical record requirements and appropriate claims coding to reduce medical collection is available in the HEDIS Quick Reference Guides.

The following standards are part of the record documentation and review process.

HEDIS review auditors require copies of measure-specific documentation located in the actual medical record.
HEDIS review auditors require a copy of the patient's registration form or demographic sheet located in the record. This information aids in verifying the customer's name and date of birth.
HEDIS measure documentation is time-specific. Requested records are for the **prior** year or earlier. [i.e., HEDIS 2021 = calendar year 2020 or earlier].
Customer name and date of birth should appear clearly on all pages of the documentation.
Customer name changes due to marriage, divorce, adoption, etc. should be clearly documented in the medical record.
Complete dates (mm/dd/yyyy) should be on each entry.
Names of other specialists, physicians, and/or facilities that treat patients should be documented.
The immunization history should be included for children and adolescents.
For colorectal and cervical cancer screening, it is important to document the date when the diagnostic procedure was performed and the results. A recommended practice is to obtain the actual diagnostic reports for your records.
For customers being monitored due to hypertension, documentation of the most recent outpatient blood pressure reading should be clearly documented with date of service and both systolic and diastolic levels clearly indicated.
For customers being monitored due to diabetes, obtain all ophthalmologist or optometrist reports for dilated retinal exams. Ensure that results of the exam are clearly indicated in the report.
For requested lab results such as HbA1c, include date of the lab and the actual lab results in the medical record.
For pediatric and adolescent well care visits, ensure that date of visit(s) and documentation including body mass index (BMI) percentiles, height, weight, along with counseling referrals and anticipatory guidance provided for nutrition and physical activity are clearly indicated.
For adult customers, body mass index, weight and height should be clearly documented at least every two years.

Legal Statement

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Together, all the way.™