

CIGNA REFERENCE GUIDE

For physicians, hospitals, ancillaries, and
other health care professionals

GO YOU™

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Introduction

Inside the guide

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

Your Cigna Participating Provider Agreement and this Reference Guide describe the terms under which you agree to provide services to Plan Participants. Those terms include the reimbursement rates applicable to Covered Services provided to Participants. However, the actual benefits payable by a Payor for Covered Services provided to a Participant in all cases is determined exclusively by the terms of the Payor's Benefit Plan.

The Reference Guide applies to all Cigna business including plans with access to the GWH-Cigna network. Therefore, certain information may only apply to participants who carry GWH-Cigna ID cards (with Cigna logo and GWH-Cigna indicator) and access the GWH-Cigna network, which is separate from the Cigna network.

Our commitment and mission

Cigna is committed to working with hospitals, ancillary facilities, physicians, and other health care professionals to help ensure that our customers (also referred to as "Participants" in your Cigna Participating Provider Agreement) have access to quality services and benefits. 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 health care professional surveys and we welcome your feedback. Working together, we believe we can attain optimal outcomes.

Contact us

Please contact us if you have questions about the information in this guide, or our plans and programs. The terms of your agreement or applicable law supersede this guide if a conflict between this reference guide and your agreement with Cigna or applicable law arises.

Note

The term "health care professional" used throughout this guide is referred to as "provider" in your participating provider agreement.

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 (Southern, IL) Illinois (Northern, 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)	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)	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.

How to Contact Us

If you want to:	For inquiries about patients with Cigna ID cards:	For inquiries about patients with GWH-Cigna ID cards
<p>Perform the following online transactions:</p> <ul style="list-style-type: none"> • Verify patient eligibility • Inquire about patient coverage and covered services • Estimate the total cost of service and patient liability for specific medical procedures • Request precertification for services • View claim-coding policies and payment guidelines • Review medical or pharmacy coverage positions • View the drug list • View sample ID cards • Update address information • Obtain a Health Care Professional Reference Guide • Request a copy of your contract • Request fee schedule information (Cigna only) 	<p>Cigna for Health Care Professionals website: CignaforHCP.com</p> <p>To view the existing list of outpatient precertification requirements, as well as planned changes, log in to CignaforHCP.com > Precertification under Popular Links.</p>	<p>Cigna for Health Care Professionals website: CignaforHCP.com</p> <p>To view the existing list of outpatient precertification requirements, as well as planned changes, log in to CignaforHCP.com > Precertification Policies under Useful Links.</p>
<p>Perform the following electronic data interchange (EDI) transactions:</p> <ul style="list-style-type: none"> • Verify patient medical, dental and behavioral 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 	<p>Cigna Payer IDs:</p> <ul style="list-style-type: none"> • 62308* medical (including GWH-Cigna), behavioral, dental, and Arizona Medicare Advantage HMO) • SX071 Employee Assistance Program (EAP) claims • 59225 Starbridge® Beech Street claims <p>*Both primary and secondary (COB) claims can be submitted electronically to Cigna.</p> <p>For a list of available vendors go to Cigna.com/edivendors or on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Claim Policies and Procedures > How to Submit Claims)</p>	<p>Use Cigna Payer ID 62308* for claims.</p> <p>*Both primary and secondary (COB) claims can be submitted electronically to Cigna.</p> <p>For a list of available vendors go to Cigna.com/edivendors or on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Claim Policies and Procedures > How to Submit Claims)</p>

How to Contact Us

If you want to:	For inquiries about patients with Cigna ID cards:	For inquiries about patients with GWH-Cigna ID cards
Perform the following through telephone transactions: <ul style="list-style-type: none"> • 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 	1.800.88Cigna (882.4462)	1.866.494.2111 Please verify the appropriate customer service number on the participant's ID card
Submit or inquire about an appeal or dispute	1.800.88Cigna (882.4462) Cigna National Appeals PO Box 188011 Chattanooga, TN 37422 Fax: 1.877.815.4827	1.866.494.2111 Cigna GWH-Cigna National Appeals PO Box 668 Kennett, MO 63857 Fax: 1.877.804.1679
Inquire about fee schedule or reimbursement terms for multiple patients	1.800.88Cigna (882.4462)	1.866.494.2111
Submit or inquire about health care professional credentialing	1.800.88Cigna (882.4462)	1.888.663.8081
Obtain information about organ and tissue transplant network	Cigna LifeSOURCE Transplant Network® <ul style="list-style-type: none"> • CignaLifeSource.com • 1.800.668.9682 	Cigna LifeSOURCE Transplant Network® <ul style="list-style-type: none"> • CignaLifeSource.com • 1.800.668.9682
Find out about Specialty Pharmacy medications (i.e., injectable medications for certain diseases) <ul style="list-style-type: none"> • TheraCare (specialty therapy management program) 	Cigna Specialty Pharmacy 1.800.351.3606 TheraCare 1.800.633.6521	Cigna Specialty Pharmacy 1.800.351.3606 TheraCare 1.800.633.6521
Prior Authorizations (small molecule and specialty drugs)	Prior Authorizations 1.800.244.6224	Prior Authorizations 1.800.244.6224
Obtain information on our Medical Management programs (including precertification)	<ul style="list-style-type: none"> • 1.800.88Cigna (882.4462) • CignaforHCP.com • Refer to the participant's ID card 	<ul style="list-style-type: none"> • 1.866.494.2111 • CignaforHCP.com • Refer to the participant's ID card
Obtain information on Behavioral Health	Benefit information: 1.800.926.2273 Find a behavioral health care professional: CignaBehavioral.com	Benefit information: 1.866.494.2111 or contact the number on the patient ID card Find a behavioral health care professional: CignaBehavioral.com

How to Contact Us

If you want to:	For inquiries about patients with Cigna ID cards:	For inquiries about patients with GWH-Cigna ID cards
Contact our high-technology radiology vendor	MedSolutions® (for all markets except as noted below): www.medsolutionsonline.com 1.888.693.3211 For these markets: AK, HI, ID, IA, MI, MN, MT, MS, NE, NM, ND, SD, WV, WY: Cigna Cigna.com 1.800.88Cigna (882.4462)	MedSolutions® www.medsolutionsonline.com 1.888.693.3211
Obtain more information on nuclear cardiology precertification	MedSolutions® www.medsolutionsonline.com 1.888.693.3211	MedSolutions® www.medsolutionsonline.com 1.888.693.3211
Contact our laboratory services vendors	Access our online directory at http://www.cigna.com/web/public/hcpdirectory	Laboratory Corporation of America (LabCorp) - www.labcorp.com Quest Diagnostics www.questdiagnostics.com
Obtain information on our chiropractic services	See State-Specific Reference Guide, the National Vendor Section , or contact Cigna at 1.800.88.Cigna	See State-Specific Reference Guide, the National Vendor Section , or contact Cigna at 1.800.88.Cigna
Contact a dental network	Cigna.com 1.800.Cigna24 (244.6224)	1.866.494.2111
Obtain other telephone numbers and addresses	Refer to the participant's ID card	Refer to the participant's ID card
Click here for a printer-friendly version of this How to Contact Us directory.		

Demographic Information and Directories

Demographic Information and Directories

We use your demographic information to:

- Publish online provider directories
- Send communications to health care professionals
- Process claims

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 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 may result in delayed changes to the provider directories and incorrect claim payments. The latest health care professional directory is available at Cigna.com.

Submit demographic changes to Cigna electronically or by mail using the form available at CignaforHCP.com > eServices > Provider Directory Changes or <https://cignaforhcp.cigna.com/healthcare/provider/app/prot/req/pdfform.do>. You must be a registered user of the secure Cigna for Health Care Professional (CignaforHCP.com) website to access this form.


You may also submit demographic changes using the following phone, fax and email addresses, based on the state your office is located.

	Cigna	GWH-Cigna
Connecticut, Delaware, Illinois, Indiana, Iowa, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, West Virginia, Wisconsin	<ul style="list-style-type: none"> • Phone: 1.800.88Cigna (882.4462) • Fax: 1.877.358.4301 • Email: providerdata@Cigna.com 	<ul style="list-style-type: none"> • Phone: 1.888.663.8081 • Fax: 1.877.358.4301 • Email: providerdata@Cigna.com
Alabama, Arkansas, Florida, District of Columbia, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, Virgin Islands	<ul style="list-style-type: none"> • Phone: 1.800.88Cigna (882.4462) • Fax: 1.888.208.7159 • Email: pdmtampa@Cigna.com 	<ul style="list-style-type: none"> • Phone: 1.888.663.8081 • Fax: 1.888.208.7159 • Email: pdmtampa@Cigna.com
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Kansas, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	<ul style="list-style-type: none"> • Phone: 1.800.88Cigna (882.4462) • Fax: 1.860.687.7336 • Email: pdmglendale@Cigna.com 	<ul style="list-style-type: none"> • Phone: 1.888.663.8081 • Fax: 1.860.687.7336 • Email: pdmglendale@Cigna.com

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* (Offered as HMO POS and Network POS)	HMO Open Access	Network Open Access	Local Plus In Network	DAP – In Network (ASO or AEB Funding only)	POS Open Access* (Offered as HMO POS Open Access and Network POS Open Access)	Local Plus	Open Access Plus	EPO True Access (ASO or AEB Funding only)	PPO	Indemnity
Benefit Plan Type	Managed Care Benefit Designs											PPO Benefit Designs		Indemnity Benefit Designs
PCP selection criteria	PCP selection required				PCP selection optional							No designation of PCP available		No designation of PCP available
Specialty Care Referral Requirements	Referral for Specialty Care Required (excluding OB/Gyn or other state-mandated direct access)				No Referral Required							No Referral Required		No referral required
Out of Network Benefits	Network Only		Out of network available	Network Only			Out of network available				Network Only	Out of network available	N/A	
Choice Fund available	No	No	No	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CIGNA Care Network	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A
Inpatient Pre-certification	Inpatient pre-certification is always required except in emergency											Inpatient pre-certification is always required except in emergency		Inpatient pre-certification required except in emergency (member responsibility)
Outpatient Pre-certification	Refer to covered individual's ID card for outpatient pre-certification requirements											Refer to covered individual's ID card for outpatient pre-certification requirements No		N/A

Benefit Plan Designs and Features

Plan	Highlights
<p>Point-of-Service (POS) Open Access</p> <p>In- and out-of-network coverage</p> <p>Specialist care covered without a referral</p>	<p><u>Point-of-Service (POS) Open Access</u> plan participants can visit in-network or out-of-network specialists without a referral. You are responsible for obtaining precertification for all in-network services when required. To determine if precertification is required, please visit the Cigna for Health Care Professionals website (CignaforHCP.com > Clinical Reimbursement Policies and Payment Policies > Precertification Policies).</p> <p>Highlights:</p> <ul style="list-style-type: none"> • Primary care physician (PCP) optional: The use of a PCP is encouraged, but not required. • Referrals are required for coverage at the in-network benefit level. • 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). • Most payment responsibilities and precertification requirements for your patients are shown on their ID card.
<p>HMO and Network Network-only coverage</p>	<p><u>Network-only plans.</u> At enrollment, participants select a primary care physician (PCP) from our broad network of participating physicians.</p> <p>Highlights:</p> <ul style="list-style-type: none"> • PCP-coordinated care. • Referrals are required. • You are responsible for obtaining precertification for all in-network services, when required. • In-network coverage only. • 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.

Benefit Plan Designs and Features

Plan	Highlights
<p>Open Access Plus and Open Access Plus In-Network (OAP)</p> <p>Specialist care covered without a referral</p>	<p><u>The Cigna Open Access Plus</u> plan gives participants referral-free access to specialists. If participants choose an out-of-network health care professional, services are covered at a reduced benefit level.</p> <p><u>The Cigna Open Access Plus In-Network</u> plan also provides referral-free access to specialty care. However, participants must visit health care professionals in the Open Access Plus network to receive benefits (only emergency and urgent care is covered when received from out-of-network health care professionals).</p> <p>Highlights:</p> <ul style="list-style-type: none"> • Primary care physician (PCP) optional: the use of a PCP is encouraged, but not required • No referrals are required. • 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 in this Reference Guide). • Most payment responsibilities and precertification requirements for patients are shown on their ID card.
<p>LocalPlus and LocalPlus IN</p> <p>A narrow network composed of a select group of Participating Health Care Professionals.</p>	<p><u>The LocalPlus</u> plan gives participants referral-free access to in-network specialists. If participants choose an out-of-network health care professional, services are covered at a reduced benefit level.</p> <p><u>LocalPlus In-Network</u> plan also provides referral-free access to specialty care. However, participants must visit health care professionals in the LocalPlus network to receive benefits (only emergency and urgent care is covered when received from out-of-network health care professionals).</p> <p>Highlights:</p> <ul style="list-style-type: none"> • Primary care physician (PCP) optional: the use of a PCP is encouraged, but not required. • No referrals are required. • 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 in this Reference Guide). • Most payment responsibilities and precertification requirements for patients are shown on their ID card.

Benefit Plan Designs and Features

<p>PPO and EPO True Access Self-directed health care</p>	<p><u>PPO</u> 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.</p> <p><u>EPO True Access</u> 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.</p> <p>Highlights:</p> <ul style="list-style-type: none"> • No option to select a primary care physician (PCP) • PCP use is not encouraged. • No referrals are 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 participant payment responsibilities and precertification requirements for patients are shown on their ID card.
<p>Cigna Care Network®</p> <p>Availability depends upon state approval for benefits and/or funding arrangement.</p>	<p>Under the <u>Cigna Care Network</u> plan, a subset of participating physicians in 22 specialties are recognized as Cigna Care designated health care professionals based on specific selection criteria. Although all Cigna participating health care professionals are considered in-network, a lower copayment or coinsurance level may apply if the covered participants choose a Cigna Care designated physician.</p> <p>Highlights:</p> <ul style="list-style-type: none"> • The usual contracted rates for covered services provided to covered participants continue to apply regardless of a health care professional's Cigna Care designation. Covered participants enrolled in a plan with the Cigna Care Network benefit design may have incentives to consider when using services from Cigna Care designated physicians. These incentives may take the form of a lower copayment or coinsurance level. • In-network, non-Cigna Care designated health care professionals will continue to see covered participants whose benefit plans do not include the Cigna Care Network benefit design. For these participants, the benefit incentive for Cigna Care Network designated specialists described above does not apply.

Benefit Plan Designs and Features

<p>Indemnity Self Directed, Non-Network Healthcare</p>	<p><u>Indemnity</u> plan participants can visit any health care professional. They do not choose a primary care physician (PCP) to coordinate their care and treatment, and they do not need a referral to see a specialist.</p> <p>Highlights:</p> <ul style="list-style-type: none">• 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.
<p>Log in to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Medical Plans and Products) for additional information regarding Cigna benefit plans and products.</p>	

Cigna Products

Cigna Participants Only

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 (if funds are available) for coinsurance and deductibles. This reduces the need to collect funds from the patient at the point of service.

What You Need to Know

- Preventive care visits are paid at 100 percent for most Choice Fund medical plans.
- These plans typically do not include copayments.
- Most individuals with a Cigna Choice Fund 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 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.
- 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 our website at Cigna.com/health/provider/medical/ccf.html or call 1.800.88Cigna (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 health care professional 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 www.cigna.com/expenses or <http://www.irs.gov/publications/p969/index.html>. You can also call Cigna Customer Service at 1.800.88Cigna.

ID Cards – Quick Guide

Link to sample ID Cards	CignaforHCP.com > Resources > Using ID Cards.
Guide to the GWH-Cigna Network	CignaforHCP.com > Resources > Medical Resources > Communications > GWH-Cigna Network.

Strategic Alliances

Cigna Participants Only

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 health care professionals in the alliance plan’s select geographic area. In other locations, participants access care through the Cigna network.

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

CareLinkSM (Alliance with Tufts HealthPlan)

Effective: January 1, 2006 **Service Area:** Massachusetts and Rhode Island

Contract Information:

Participants with a CareLink logo on their ID card have access to the Tufts HealthPlan health care professional network in MA and RI for in-network coverage. Health care professionals 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 health care professionals.

Additional Information:

You can contact Tufts HealthPlan at 1.888.884.2404 or by visiting their website, www.tuftshealthplan.com/providers/provider. The CareLink (Tufts HealthPlan) Quick Reference Guide is available on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Reference Guides > Medical Reference Guides > CareLink [Tufts HealthPlan] Quick Reference Guide).

Health Alliance Plan (HAP)

Effective: January 1, 2006

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:

Health care professionals in this service area must be contracted through HAP to be considered in-network. Outside the service area, HAP participants have access to the Cigna national network of participating health care professionals.

Additional Information:

You can contact HAP customer service at 1.888.999.4347 or by visiting their website, 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, and South Dakota

Contract information:

Health care professionals in this service area must be contracted through HealthPartners to be considered in-network. Outside the service area, HealthPartners participants have access to the Cigna national network of participating health care professionals.

Additional Information:

The Quick Reference Guide is available online at (www.healthpartners.com > Providers > HealthPartners/Cigna Alliance [under "Information"]). 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).

MVP Health Care

Effective: July 1, 2007

Service Area: Upstate New York

Contract Information:

Health care professionals 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 health care professionals, except in VT, CT, and NH, and in parts of NY, PA, and Western MA.

Additional Information:

You can contact MVP at 1.888.687.6277 or by visiting their website, 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 (Cigna Health and Life Insurance Company and Connecticut General Life Insurance Company) contracts with Taft Hartley trusts and federal employee health benefit plans to share the administration of their self-funded (ASO) plans. For these relationships, Cigna provides access to our 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 to encourage patients to use health care professionals who participate in the Cigna network.
- Cigna performs pre-contract checklist to ensure TPAs meet our standards for claim payment accuracy, payment turn-around time, and call statistics (speed of answer etc.). Additionally, adherence to these standards is contractually obligated.
- Cigna audits all TPAs regularly to help ensure compliance with contract standards. Cigna also monitors service in conjunction with network staff through random call testing
- 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 health care provider contract language and intent.
- Participants in these plans with Medicare Primary do not participate through Cigna. 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 patient's ID card.

Medical Management: All inpatient utilization review for acute, rehabilitation, and skilled nursing and case management is provided through Care Allies (Cigna's medical management subsidiary). Clients may purchase review of outpatient services (e.g., ambulatory surgery, high-technology radiology, etc). Participants are aware of these requirements. Additionally, we enlist support from these participants' health care professionals to provide notice and obtain authorization.

Eligibility/Benefits/Claim Status and Payment: For information related to these topics, please contact the TPA telephone number and address listed on the patient's ID Card.

Cigna Products

Claim Flow: Please submit claims directly to Cigna using the Cigna electronic payer ID 62308 or to the mailing address listed on the patient'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 patient's eligibility and benefits. The Shared Administration client then remits payment following contractually agreed-upon turnaround requirements.

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 per the standard process.

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 GWH-Cigna PPO network, performs 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 shared accounts on their own systems.

- Cigna requires our payer partners 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 health care professionals who participate in the Cigna network.
- Cigna performs a pre-contract checklist to help ensure, among other things, payers meet our standards for claim payment accuracy, payment turn-around time, call statistics (speed of answer etc.). Additionally, adherence to these standards is contractually obligated.
- Cigna audits payers regularly 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 health care professionals with contracting questions. For claim-related inquiries, contact the TPA listed on the customer's ID card.

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

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 patient's ID card.

Cigna and GWH-Cigna Networks

Cigna maintains two networks: Cigna and GWH-Cigna. There are separate claim and service channels for each network. You can identify the network a patient uses by the ID card. When making referrals, keep in mind that your patients with a GWH-Cigna ID card may access a separate list of vendors than your patients with a Cigna ID card.

Please refer to the patient's ID card to identify the correct network and to determine how to verify eligibility, obtain precertification and submit claims for the patient.

ID card resources, including samples, are available for your reference:

Resource	Cigna
Website	Cigna for Health Care Professionals website (CignaforHCP.com)
Link to sample ID cards If possible, it would be better to include some sample ID cards here rather than a link to them	CignaforHCP.com > Resources > Using Cigna ID Cards
Important Contact Information	CignaforHCP.com > Resources > Medical Resources > Communications > GWH-Cigna Network > Important Contact Information
Guide to the GWH-Cigna Network	CignaforHCP.com > Resources > Medical Resources > Communications > GWH-Cigna Network > or by clicking https://cignaforhcp.cigna.com/public/content/pdf/resourceLibrary/medical/QuickRefGuide_NewGWHCards.pdf

eServices for Health Care Professionals

We want to help you make the most of your time and provide convenient tools to help you 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	
<p>Cigna for Health Care Professionals website (CignaforHCP.com)</p>	<p>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.</p>
<p><u>Cigna Cost of Care Estimator®</u></p> <p>Applies to Cigna participants only</p>	<ul style="list-style-type: none"> • Provides personalized estimates of the amount your patients will owe for specific medical services. • Helps facilitate financial discussions between you and your patients in Cigna-administered or insured medical plans so payment arrangements can be made before treatment. • Helps 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 benefits influence what they can expect to owe. • Available on the secure Cigna for Health Care Professionals website (CignaforHCP.com > Patients > Search Patients > Select a Patient > Estimate Costs). • Available for plan participants in these Cigna-administered or insured medical plans: <ul style="list-style-type: none"> – Preferred Provider Organization (PPO) – Exclusive Provider Organization (EPO) – Open Access Plus (OAP) and Open Access Plus In-Network (OAPIN) – 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

eServices for Health Care Professionals

Quick Summary of Key Tools	
<u>Electronic Data Interchange (EDI)</u>	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 <u>electronic remittance advice</u> (ERA).
<u>Electronic Funds Transfer (EFT)</u> Applies to Cigna Participants only	<u>EFT</u> , 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 .
<u>Online Remittance Reports</u> Applies to Cigna participants only	If you are enrolled to receive payments using electronic funds transfer (EFT), you can: <ul style="list-style-type: none"> • 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).
<u>1.800.88Cigna (882.4462)</u> Applies to Cigna participants only 1.866.494.2111 Applies to participants with GWH-Cigna ID cards only	This interactive voice response telephone system provides access to eligibility, benefit and claims status information, precertification information, credentialing status and more.
<u>ePrescribe</u>	Provides access to prescription eligibility, drug list and medication history for your patients covered by Cigna Pharmacy plans, and the ability to send electronic prescriptions to pharmacies.
<u>Online Learning: eCourses</u>	Give you 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.)

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:	
<u>Eligibility and Benefits</u>	<ul style="list-style-type: none"> • Access specific information about your patients covered by a Cigna plan • View coinsurance, deductibles and plan maximums • Search for up to 10 patients at once
<u>Estimate Patient Liability</u> (Cigna participants only)	<ul style="list-style-type: none"> • Determine the total cost of a service or treatment • Determine how much Cigna estimates it will pay for the service or treatment • Provide an estimate of what the patient will owe out of pocket
<u>Online Precertification</u>	<ul style="list-style-type: none"> • 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
<u>Claim Information</u>	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Enroll in EFT • Check the status of your EFT enrollment • Change EFT settings • Change your report delivery preferences
<u>Online Remittance Reports</u>	<ul style="list-style-type: none"> • Available for health care professionals 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

eServices for Health Care Professionals

You can also:	<ul style="list-style-type: none">• 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
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To register and begin using the Cigna for Health Care Professionals website:

1. Go to CignaforHCP.com
2. Click “Register Now”
3. Follow the automated registration process

If we can 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 fully 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
 - Injectable medications, when covered under the medical plan
- 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

eServices for Health Care Professionals

- Available for Cigna participants by logging in to the secure Cigna for Health Care Professionals website (CignaforHCP.com > Patients > View & Submit Precertifications Requests).
- For participants with GWH-Cigna ID cards, log in to the Secured Provider Portal (GWHCignaforHCP.com > View and Submit Precertification Requests).

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 abuse, 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 health care professionals in your office, or to register, call NaviNet Customer Care at 1.888.482.8057

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, ERA, or online remittance report
- Look up a remittance report using:
 - The Remittance Tracking Number
 - Patient's name or ID number and date of birth
 - The Claim/Reference number
 - The deposit amount and/or date of deposit
- 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 tool, available on the Cigna for Health Care Professionals website (CignaforHCP.com) helps eliminate financial surprises by estimating the cost of the medical service, highlighting the participant's anticipated payment responsibility, and providing you and your patients with an itemized, printable Explanation of Estimate. It's 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 health care professionals 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) to multiple payers 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 funds transfer](#) (EFT), or direct deposit

Electronic Transaction Support Options

You have two options for exchanging EDI transactions with Cigna: by directly connecting to the Cigna system using software from Post-n-Track®, or through other EDI vendors.

Post-n-Track – Post-n-Track software is available at no cost to health care professionals in the Cigna network, is easy to use and install, and can be downloaded in less than five minutes. No changes are required to your existing claim system. To enroll, contact Post-n-Track at 860.257.2030, or log in to Post-n-Track.com and click “Enroll.”

Other EDI vendors – To provide you with more connectivity options, we continue to add to the list of connected EDI vendors. For the latest 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 IDs for Submitting Electronic Claims

Payer ID	Claim type
62308	Medical (including GWH-Cigna), behavioral, dental, and Arizona Medicare Advantage HMO
86033	Employee Assistance Program (EAP)
59225	Starbridge Beech Street

*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

- 1.800.88Cigna (882.4462) – for your patients with Cigna ID cards
- 1.866.494.2111 – for your patients with GWH-Cigna ID cards

We offer quick access to eligibility, benefit and claim information by calling 1.800.88Cigna (882.4462) for your patients with Cigna ID cards, and 1.866.494.2111 for your patients with GWH-Cigna ID cards. You may use our interactive voice response (IVR) automated telephone system, anytime or speak to a Cigna Customer Service Representative Monday through Friday, 8 a.m. to 6 p.m. EST.

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, 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 health care professionals for your patients covered by Cigna Pharmacy 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 Cigna 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.

For more information about ePrescribing and the software and hardware needed to access this important information, visit the eHealth Initiative website – ehealthinitiative.org – for their Clinicians’ Guide to Electronic Prescribing.

Online Training and Resources

eCourses

Cigna offers eCourses to give you access to free, online learning material about our electronic capabilities, timely health care topics, and other important information. eCourses are always available and do not require any special software. You can view any of the courses electronically at your convenience, or simply download a course and save a copy to your computer to review later or print for your files.

eCourses are available on the Cigna for Health Care Professionals website (CignaforHCP.com >Resources > eCourses).

Cultural Competency

Cultural competency resources are available to health care professionals on the Cigna.com and CignaforHCP.com websites. You will be able to access links to resources at no extra cost to you. 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

Health Care Professional Participation

Health Care Professional Participation

Cigna contracts with physicians, physician groups, associations and delivery systems, hospitals, ancillary practitioners and facilities, and other health care professionals to participate in our networks for the purpose of providing care for participants.

As a participating health care professional, 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 Physician (PCP) Services

The PCP coordinates care for participants who choose a PCP. Coordinating a participant's care can include providing treatment, referring to participating specialists or other health care professionals 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 (SCP) Services

The SCP provides specialty medical services to participants with Cigna coverage referred by a PCP or 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 health care professionals and renders services as appropriate. The SCP must comply with Cigna medical management programs, including Utilization Management, Quality Management and Prescription Drug Programs.

Health Care Professional Participation

Service Standards and Requirements

Participants in Cigna-administered or insured plans expect quality health care services. You can assist us in maintaining 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 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 – 1.800.88Cigna (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

Health Care Professional Participation

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.

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 health care professional 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.

Health Care Professional Participation

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.

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: Copayment plans require participants to pay a fixed dollar amount (copayment) 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. Deductibles may apply to these types of plans. Deductible amounts should not be collected at the time of service unless you use the [Cigna Cost of Care Estimator®](#) to obtain an estimate of the patient's deductible obligations and provide a copy of the estimate to the patient at the time of service. If you over collect the customer's anticipated liability at the time of service, you should be prepared to promptly issue a refund of the difference directly to the patient.

Health Care Professional Participation

Coinsurance & 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 plans of their estimated financial responsibility for medical services based on their specific Cigna administered medical plan. The Estimator is available for all plan participants in 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) and Open Access Plus In-Network (OAPIN) plans and Local Plus), and participants with Cigna-administered Choice Fund 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 the secure Cigna for Health Care Professional 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...

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.

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.

Health Care Professional Participation

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 participation agreement or Program Requirements/Administrative Guidelines, including Cigna utilization management requirements and timely filing requirements.

Confidentiality

Cigna maintains strict policies to protect confidential information. As a participating health care professional, 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 1.800.88Cigna (882.4462).

Medical Records

This Information Pertains to Hospitals and Ancillary Facilities Only.

Cigna safeguards participant information and expects the same standard of you. To help ensure participant confidentiality and privacy, you must maintain secure, accurate and orderly 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 business purposes during normal business hours, including medical chart reviews. 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 Program Requirements/Administrative Guidelines to the extent such consent or approval is required by law.

Health Care Professional Participation

Medical Record Reviews

This Information Pertains to Physicians and Other Health Care Professionals Only

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 health care professionals 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 and organized. 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
- Review of consultant report, if requested
- Medical history
- Visit exam coinciding with chief complaint
- 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

Physicians should ask patients if they have executed an advance directive declaration (living will or health care power of attorney) and document the response on their medical record.

You must allow Cigna personnel access to participants' medical records for appropriate Cigna business purposes during normal business hours, including medical chart review. 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 Program Requirements/Administrative Guidelines to the extent such consent or authorization is required by law.

Credentialing

Credentialing for Physicians and Health Care Professionals

Health care professionals 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 1.800.88Cigna (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 www.CAQH.com .
Sign the contract and return it to the address provided in the letter.

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 health care professionals 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. Health care professionals 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 health care professionals 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 www.CAQH.org. For questions about completing the application, call the CAQH Help Desk at 1.888.599.1771 or email CAQH at caqh.updhelp@acsqs.com.

Submitting Paper Forms

If you do not have Internet access, call CAQH at 1.888.599.1771 to request a paper application. In addition, call Cigna at 1.800.88Cigna (882.4462) to initiate the credentialing and contracting process.

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 requirements for physician participation include, but are not limited to, the following:
A completed signed and dated application (dated within 250 days). Correction liquid must not be used in the signature area. 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)
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 in a recognized specialty by the American Board of Medical Specialties (ABMS), American Osteopathic Association, American Board of Podiatric Surgery or American Board of Podiatric Orthopedics and Primary Podiatric Medicine
Unrestricted admitting privileges to at least one Cigna participating hospital, depending on the network in which you are requesting to participate. Exceptions may be granted in instances where an applicant’s specialty does not typically require admitting privileges (e.g. allergy, radiology) or where satisfactory alternative mechanism has been established (e.g. hospitalist) and documentation included. Temporary or pending privileges are not acceptable.
Professional liability insurance with typical minimum coverage of \$1,000,000 per incident and \$3,000,000 aggregate for physicians and other health care professionals
Acceptable history of professional liability claim experience as determined by Cigna
Completed professional liability form (with explanation of each case). (Not required if provided through CAQH application.)
Acceptable history of Medicare/Medicaid sanctions as determined by Cigna
Acceptable responses to all questions on the credentialing application form as determined by Cigna
A query and results from the National Practitioner Data Bank
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

You have certain rights during the credentialing process, including the right to:
Review information submitted to support your application, including information from outside sources
Correct erroneous information if credentialing information obtained from other sources varies substantially from what you provided
Be informed of the status of your credentialing or recredentialing application.

The decision to accept or deny participation will be communicated in writing.

Credentialing Criteria Verified Through Office Site Visit

For PCPs and OB/GYNs practicing in Texas and for PCPs practicing in Tennessee, the following criteria must be verified through an office site visit by a Cigna representative:
Adequate physician coverage and accessibility to participants
Appropriate arrangements for 24-hour on-call coverage for emergencies
Routine appointment booking of not more than five patients per hour; six patients per hour for pediatric offices

Requirements include an office that:
Is clean and presentable
Has adequate waiting room space with comfortable seating for at least five people per physician; 10 seats per physician for pediatric offices
Has at least two exam rooms per physician that are well lighted and provide privacy for patients, with examination equipment (otoscope, ophthalmoscope, blood pressure cuff, scale) readily accessible
Has easy access to a clean, properly supplied bathroom
Has support staff who are helpful and display a sense of professionalism and helpfulness
Has medical records that meet Cigna standards for organization, completeness and confidentiality

Cigna will evaluate exceptions to certain of its credentialing criteria on a case-by-case basis.

Notice of Material Changes

As a participating health care professional, you are responsible for notifying Cigna immediately of any material 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 the Cigna or GWH-Cigna networks.

Termination Appeal Process

You may appeal our decision to terminate your Cigna Agreement based on a:
Quality of Care reason.
Quality of Service reason.
Failure to meet our credentialing requirements, if you participate in a state with a regulatory mandate that appeal rights are to 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.

Recredentialing Process

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:
Original signature and date of signature (can be done through the CAQH Universal Provider Data Source application)
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

Credentialing

Record of adequate education and board certification for any new specialty in which you request to be credentialed
Verification of unrestricted admitting privileges to at least one Cigna participating hospital, dependent upon the network participation being requested. Exceptions may be granted in instances where a health care professional's specialty does not typically require admitting privileges (e.g. allergy, radiology), or where a satisfactory alternative mechanism has been established (e.g. hospitalist), and documentation included
Professional liability face sheet to ensure professional liability coverage meets Cigna requirements
Acceptable history of professional liability claim experience as determined by Cigna
Completed professional liability form with explanation of each case; (not required if provided through CAQH application)
Written explanation relevant to professional liability and practice review questions
Acceptable history of Medicare/Medicaid sanctions as determined by Cigna
A query and results from the National Practitioner Data Bank
Acceptable responses to all questions on the credentialing application form as determined by Cigna

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 the criteria referenced above.

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

Signed, dated and completed professional liability form (Form A) (not required if submitted through CAQH)
Copy of current DEA and CDS (if applicable) certificates
Copy of current professional liability face sheet if liability coverage is not listed in the CAQH application

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	Occupational Therapists
Physician Assistants	Physical Therapists	Speech Therapists

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

Credentialing for Hospitals and Ancillary Facilities

To help ensure Cigna network health care professionals 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 performs 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 and Medicaid Services (CMS) evaluation
An onsite assessment, if not accredited or Medicare/Medicaid certified

A copy of the Quality Management Plan, if not accredited or Medicare/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.

Recredentialing Requirements for Facilities

Participating hospital and ancillary facilities are recredentialled every three years or more frequently if required by applicable law. Cigna credentialing staff will confirm that the hospital/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 health care professional network are dependent upon the hospital or ancillary facility continuing to meet the Cigna credentialing and recredentialing standards.

Types of Hospitals and Ancillary Facilities to be Credentialed

Cigna credentials and recredentialings, but may not be limited to, the following types of hospitals and facilities:	
Hospitals (i.e., acute, subacute, transitional, or rehabilitation)	Home health agencies (nursing and home infusion)
Long term care facilities (skilled nursing facilities or 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/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 1.800.88Cigna (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 identification card or enrollment form (if they are awaiting receipt of an ID card) as proof of coverage.

Eligibility Verification

In addition to viewing the 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

You have two options for [exchanging EDI transactions](#) with Cigna: by directly connecting to our systems using software from Post-n-Track, or through other EDI vendors.

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 patients covered by managed care plans
PHS and PHS+ medical management identification
Coordination of benefits information (Medicare Part A, Medicare Part B, or other)
Primary care physician (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 offer clients two core medical management models: Personal Health Solutions (PHS) and Personal Health Solutions Plus (PHS+). Both of these models include prospective, concurrent, and retrospective reviews, as well as case management services and 24/7 access to health information and case management services.

Note: *This information may apply to health care professional 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.
- Inpatient case management (concurrent stay review) generally begins on the approved Milliman Care Guidelines[®] length-of-stay plus two days, or as indicated by the diagnosis, for participants still in the inpatient setting.
- Nurses can provide telephone or on-site inpatient case management for participants, as well as referrals to ongoing case management post-discharge, if appropriate.

Personal Health Solutions Plus (PHS+)

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

- Inpatient case management (continued stay review) generally begins on the first day of hospitalization, or on the approved Milliman Care Guidelines length-of-stay minus one day.

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 health care professional 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 are 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 PHS and PHS+ 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/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.

Medical Management Program

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 mandate.

The following information is typically required for precertification:

- Participant name and ID number
- Participant date-of-birth
- Diagnosis including ICD-9-CM
- Requesting or referring health care professional
- Servicing health care professional, 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 > 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.

Utilization Management – Precertification of Outpatient Services

With the PHS+ model, 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 health care professional 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 have extenuating circumstances or those services that are performed in an emergency room. In these cases, an appeal may be needed to show that 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 health care professional 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 health care professional 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 “Emergent, Urgent, or Extenuating Circumstances” criteria (as outlined below), the health care professional 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 health care professional 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 health care professional 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 health care professional 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+ model 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 > Useful Links > Precertification Policies).

The following is a list of outpatient services that **must be precertified** under standard PHS+ benefit plans, as of January 1, 2013.

• Air ambulance	• Anesthesia and/or facility fees for non-covered dental services
• Back and spine	• Biofeedback
• Cardioverter- Defibrillator Pulse Generators	• Cochlear implants
• Cosmetic procedures	• Dental implants
• Elective MRA, MRI, MRS, CT, and PET scans	• Electronical stimulation/ transcutaneous electrical nerve stimulation (TENS)/osteogenesis stimulation
• External prosthetic appliances (some codes)	• Gastric bypass – inpatient or outpatient
• Genetic testing	• Home health care
• Home infusion therapy, when provided by a fee-for-service or discount provider	• Implants
• Infertility treatment	• Injectable medications
• Insulin pumps	• Manipulations under anesthesia

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• Neurostimulators	• New and emerging technologies
• Observation stays, excluding false labor for undelivered obstetric patients	• Orthognathic procedures
• Orthotics	• Penile implants
• Potential experimental, investigational, and/or unproven treatments	• Power operated vehicles
• Private duty nursing	• Procedures to treat injury to healthy natural teeth
• Radiation therapy	• Seat lifts
• Skin substitutes	• Sleep studies
• Specialty oxygen systems	• Special wheelchairs
• Speech generating devices	• Speech therapy
• Temporomandibular Joint Syndrome procedures (TMJ)	• Therapeutic radiology
• Transplants	• Unlisted procedures
• Uvulopalatopharyngoplasty	• Varicose vein treatment

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., Milliman Care Guidelines). 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.

Medical Management Program

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 references that are applied by us are available at CignaforHCP.com, or by calling 1.800.88Cigna (882.4462).

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.

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

We require the National Drug Code (NDC) number be included in addition to the Healthcare Common Procedure Coding System (HCPCS) code on some claims, when the individual's health plan requires precertification. The list of specialty medications that are included in this requirement, details on which claims require the NDC number, information about where to include the NDC on the claim and other additional information can be found on the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > HCPCS Codes Requiring NDC).

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 “GWH-Cigna” 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 1.800.88Cigna (882.4462).

Physician Office Laboratory Tests

This information pertains to physicians and other health care professionals only

Laboratory test procedures must be performed in a laboratory by you or your staff. You will only be reimbursed for covered services that you are certified to perform through the Clinical Laboratory Improvement Amendments (CLIA). All tests for

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laboratory procedures that you are not certified to perform through CLIA must be referred to a participating laboratory provider.

Please note that pass-through billing is not permitted for tests that are not performed by you. 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 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 authorize 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 authorized.

Health care professionals can discuss a coverage denial decision with a medical director by initiating a peer-to-peer discussion. You can do this by calling 1.800.88Cigna (882.4462) or 1.866.494.2111 for individuals with GWH-Cigna 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, 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:

- 1.800.88Cigna (882.4462) for patient's with Cigna ID cards.
- 1.866.494.2111 for patient's with GWH-Cigna 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.

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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, 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 coverage at no additional charge to them or to their employers. For more information, or to refer a patient, please call 1.800.88Cigna (882.4462) (or 1.866.494.2111 for participants with GWH-Cigna ID cards). For transplant referrals, please call 1.800.668.9682.

Referral Guidelines

This information pertains to physicians and other health care professionals only

For individuals who are covered by plans that require referrals, referrals are made through the primary care physician (PCP). PCPs must:

- Provide a referral for specialty services.
- Send written documentation of a referral to the specialty care physician or health care professional. Referrals can be sent by mail or fax and may be written on a prescription or other form.

PCPs do not need to notify Cigna of a referral to a participating physician or other health care professional, but should retain documentation in the patient's medical record.

The specialty care physician or other health care professional must:

- Communicate with the PCP as appropriate about the diagnosis, treatment, or follow-up care.
- Contact the PCP for a written referral if they do not receive one.

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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 health care professional in advance if requesting in-network benefits.

Referral Process

This information pertains to physicians and other health care professionals only

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

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

Medical Management Program

Exceptions to Referral Process

Health care professional 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.

Obstetric 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 Abuse Program

Mental health and substance abuse services are generally provided through Cigna Behavioral Health, Inc. However, please verify your patient's coverage online at Cignabehavioral.com for participants with Cigna coverage.

You may 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 health care professionals 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 abuse services.

Vision Care

Some participants have direct access to routine vision care with participating vision health care professionals 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.

Claims and Compensation

Timely and accurate reimbursement is important to you and Cigna. 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.

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. Using one of Cigna's electronic data interchange (EDI) options allows you to send, view, and track claims with Cigna—no faxing, printing, or mailing. Everything is right on your desktop.

Submitting claims electronically to Cigna can help you

- 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.

You have multiple options for [exchanging EDI transactions](#) with Cigna – by directly connecting to the Cigna systems using software from Post-n-Track, or through other EDI vendors.

Cigna Payer IDs for Submitting Electronic Claims

Payer ID	Claim type
62308	Medical (including GWH-Cigna), behavioral, dental, and Arizona Medicare Advantage HMO
SX071	Employee Assistance Program (EAP)
59225	Starbridge Beech Street

* 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.

Paper Claim Submission

We strongly encourage you to submit claims electronically using Post-n-Track or through another EDI vendor 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
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These forms can also be downloaded by going to CignaforHCP.com > Resources > Forms Center > Forms > Medical Forms.

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, clearly identify it on the claim

Definition of a Complete Claim

Cigna defines a complete claim as a claim that can be processed by Cigna or its designee without additional information from the health care professional or a third party.

The claim at a minimum must include:	
Patient name and address	Location of service
Patient date of birth and sex	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-9, DRG)	Date of current illness
First date of same or similar illness	Date of service
Health care professional name, address and telephone number	Tax ID number and National Provider Identifier (if applicable)
Description of procedure(s)	Billed charge or amount for each procedure
Cigna ID Number (all digits and suffix)	Standard code sets (CPT-4, Revenue Code, HCPCS, NDC)
Note: Any state law, HIPAA transaction and code set requirements, or plan-specific language inconsistent with the Cigna Standard Program Requirements/Administrative Guidelines 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. Those addresses could potentially be locked boxes for claim payment. 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
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	<ul style="list-style-type: none"> • 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

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Claim Category	Supplemental Attachment
Drugs--Injectable	<p>Healthcare Common Procedure Coding System (HCPCS) or National Drug Codes (NDC)*</p> <p>Cigna requires the National Drug Code (NDC) number be included in addition to the Healthcare Common Procedure Coding System (HCPCS) code on some claims, when the patient's health plan requires precertification. The list of specialty medications that are included in this requirement, details on which claims require the NDC number, information about where to include the NDC on the claim and additional information can be found on the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > HCPCS Codes Requiring NDC).</p>
Experimental, Investigational or Unproven Procedures	Operative or physician notes or other clinical information
High Dollar Claims	Itemized bill
Home Health Care	<ul style="list-style-type: none"> • Office notes and treatment plan • All visit notes, complete history and physical • Infusion drug report, if applicable
<p>Modifiers:</p> <ul style="list-style-type: none"> • 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 • Other modifiers may require additional information 	<p>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.</p>
Morbid Obesity	<ul style="list-style-type: none"> • Complete history and physical • Proposed treatment plan, including any surgical procedures • Measures tried previously and patient's response

Claims and Compensation

Claim Category	Supplemental Attachment
Pre-determinations	<ul style="list-style-type: none"> • 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
Unlisted CPT or HCPCS codes (example: CPT codes ending in “99”, such as CPT Code 64999 – Unlisted procedure, nervous system)	<ul style="list-style-type: none"> • 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 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 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)

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- Resubmission of a claim originally filed in a timely manner, returned with new or additional requested information (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

Health care professionals 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:

Health care professional name	Health care professional participation number
Tax ID number	Patient name
Patient ID	Subscriber name
Date of service	Description of service
Amount of claim	Date claim was submitted

Our website is available to health care professionals for verifying claim status, based on your patient's ID card. For patients with a Cigna ID card, log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com).

You have multiple options for [exchanging EDI transactions](#) with Cigna – by directly connecting to Cigna systems using software from Post-N-Track, or through other EDI vendors.

The claim inquiry and follow-up options listed above allow health care professionals 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 2 years

By calling the number on the patient'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 health care professionals 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)..

You can also email the regional [Provider Solution Units \(PSU\)](#) with other questions or concerns.

Assistant-at-Surgery Modifiers

This Information Pertains to Physicians and Other Health Care Professionals Only

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 benefit plans cover non-physician assistants at surgery. Another participating physician should be used as an assistant-at-surgery to help the patient maximize his or her benefits.

For additional information, please refer to the "Modifiers 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	<u>Physician Assistant-at-Surgery</u> : 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.
81	Minimum Assistant Surgeon	<u>Physician Assistant-at-Surgery</u> : 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)	<u>Physician Assistant-at-Surgery</u> : 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.

Claims and Compensation

Modifier	Definition	Reimbursement Policy *
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	<p><u>Non-Physician Assistant-at-Surgery</u>: 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.</p> <p>Note: not all benefit plans cover non-physician assistants at surgery.</p>

Note: If the primary procedure requires an assistant, additional covered procedures performed by the assistant will be reimbursed, subject to our multiple procedure policy and the provider agreement, as well as our other standard claim coding methodologies (e.g., ClaimCheck®, 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 facilities or 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 when billed as two lines with modifier 50 appended.

TIPS
<ul style="list-style-type: none"> • Assistant surgeon fees are subject to the multiple procedure policy
<ul style="list-style-type: none"> • Participating physicians cannot balance bill participants for charges in excess of Cigna allowable amounts
<ul style="list-style-type: none"> • In some cases, an office visit is not separately reimbursable from the surgical code so the office visit copayment does not apply

Immunization Policy

This information pertains to physicians and other health care professionals 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 1.800.88Cigna (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.

ClaimCheck[®]

We use an automated code auditing tool known as ClaimCheck to help expedite and improve the accuracy of professional claims processing. ClaimCheck uses rules-based logic to:

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

This code auditing 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 ClaimCheck 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).

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

Participant Liability Collection Guidelines

Copayments: Copayment plans require participants to pay a fixed dollar amount (copayment) 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. Deductibles may apply to these types of plans. Deductible amounts should not be collected at the time of service unless you use the [Cigna Cost of Care Estimator[®]](#) to obtain an estimate of the patient's deductible obligations and provide a copy of the estimate to the patient at the time of service. If you over collect the customer's anticipated liability at the time of service, you should be prepared to promptly issue a refund of the difference directly to the patient.

Coinsurance & 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 plans of their estimated financial responsibility for medical services based on their specific Cigna insured or administered medical plan. The Estimator is available for all plan participants in Preferred Provider Organization (PPO), Open Access Plus (OAP) and Open Access Plus In-network (OAPIN), Exclusive Provider Organization (EPO) 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) and Open Access Plus In-Network (OAPIN) plans and Local Plus), and participants with Cigna-administered Choice Fund 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).

Claims and Compensation

For additional information about the Cigna Cost of Care Estimator log in to the secure Cigna for Health Care Professional 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 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 and 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.

Claims and Compensation

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, that 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 when the 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 constitute 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, the order of benefit determination is determined by federal law or regulation, 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

Health care professionals 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 Program Requirements and Administrative Guidelines, 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

Claims and Compensation

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 GWH-Cigna network
Cigna Attn: Mail Processing Refunds 1000 Great-West Drive Kennett, MO 63857-2749

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, also known as direct deposit, offers a secure method for funds to be deposited directly into your bank account for 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 [Cigna.com > Health Care Professionals > Resources for Health Care Professionals > Doing Business with Cigna > 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:
 - Ask your bank to provide the payment related information from field 3 of record 7 on the EFT report they send to you
 - “Reference Identification Field” (or TRN02) on your ERA
 - Number located on the right side of the first page of your online remittance report
- 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 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 > Assign Access > Modify Existing Users/Add New Users.
 - If you are not yet registered for the Cigna for Health Care Professionals 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. You can find a sample remittance report by visiting [Cigna.com](#) > Health Care Professionals > Resources for Health Care Professionals > Doing Business with Cigna > Electronic Funds Transfer (EFT).

For step-by-step instructions how access your remittance reports, go to [CignaforHCP.com > Resources > eCourses > Electronic Funds Transfer and Online Remittance Reports](#)

To sign up for EFT

- Log in to the Cigna for Health Care Professionals website (CignaforHCP.com) > Working With Cigna > Enroll in Electronic Funds Transfer (EFT) Options.
- Complete the electronic enrollment fields.
- Cigna will send 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

Important Information about EFT:

- 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.
- If your TIN, billing address or bank account changes, you must submit a change request by logging in to the Cigna for Health Care Professional website (CignaforHCP.com) > Working With Cigna > Manage EFT Settings.
- EFT is not currently available for payments associated with patients who have a GWH-Cigna ID card.
- 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)

To Enroll for ERA

- Notify your EDI vendor or Post-n-Track®* that you would like to enroll for Cigna ERA.
- Provide enrollment information as instructed by your EDI vendor or Post-n-Track (if you use more than one TIN, complete a separate enrollment information for each TIN).
- Your EDI vendor or Post-n-Track 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.

*Post-n-Track software is free to health care professionals in the Cigna network. To enroll, call Post-n-Track at 860.257.2030, or log on to Post-n-Track.com and click "Enroll." For the latest information on our EDI vendors and the transactions they support, visit Cigna.com > Health Care Professionals > Network benefits > Learn more about eServices.

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 participant, including services covered under the participant's in-network or out-of-network benefits. This is true whether it is the Payor or the participant who is financially responsible for payment.

New 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 Medical Cost Programs

We manage claims and perform reviews through various quality and medical cost programs. These programs continue to provide quality results, control medical costs, and improve our customers' experience.

Prepayment Reviews

The Prepayment Review program works in harmony with other Cigna quality initiatives to help achieve accurate claim processing. Through this program, we can proactively identify claims that may require additional attention and, when necessary, correct claims prior to payment.

Clinical Claim Reviews

The Clinical Claim Review program enables us to review facility claims for accuracy and appropriateness prior to payment. As part of this program, we may check claims against coverage or reimbursement policies and ensure coverage alignment with a patient's benefit plan. An experienced team of health care professionals, including nurses and physicians, review billing and coding for accuracy.

Postpayment Reviews

The Postpayment Review program enables us to review claims after claims are paid. Nurse and physician reviewers compare a facility's itemized bill and invoices (e.g., for implantable devices) to the events, services, and items documented in the patient's medical record. Medical coding is also reviewed to help ensure it meets current nationally recognized standards and accurately represents documented services.

Dispute Resolution

Following are the necessary requirements for submitting an appeal of a payment decision. 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. These steps can 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 for Reimbursement:

- 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.

Dispute Resolution

- 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 1.800.88Cigna (1.800.882.4462) 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.

Health Care Professional Payment Appeals

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 1.800.88Cigna (1.800.882.4462) 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 the 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 health care professional'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. Fee schedule or reimbursement terms for multiple patients do not require individual appeals. Please call Cigna Customer Service at 1.800.88Cigna (1.800.882.4462) if you need assistance.

Dispute Resolution

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 health care professional'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 process outlined in the Administrative Guidelines. If the dispute is not resolved through that process, follow the dispute resolution provisions in the Cigna Provider Agreement. The standard dispute resolution process provides 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 health care professional has completed the internal appeals process.

Note: If there is a conflict between this reference guide and your provider agreement or applicable law, the provider agreement or applicable law will govern.

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).

Health care professionals 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 and Fee Disputes

When submitting appeals related to your contract, include the following information with your Request for Provider Payment Review form or the appeal request letter:

- Previously submitted claim form (paper or electronic)
- EOP for the services being appealed
- Explanation of line items being appealed
- Payment that was expected and how it was determined by you or your office staff
- Related correspondence and any other documents that may support your position in the dispute

Multiple Patients Disputes

Fee schedule adjustments and reimbursement disputes for multiple patients may not require individual appeals. Please call Customer Service at 1.800.88Cigna (1.800.882.4462) so we may provide you with further guidance on how to submit these requests.

Claim Bundling Appeals

Before submitting the appeal request for claim bundling 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
- Medical records
- Any other relevant information including documentation of any 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).

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 health care professional 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.

Medical Necessity

If your dispute involves an issue regarding the medical necessity of a service or procedure in addition to a pricing concern, a clinician will review the non-pricing part of your appeal. If your dispute contains a benefits issue in addition to a pricing issue, the Plan's benefits will be reviewed and our response will refer to those benefits.

Most appeals are resolved within 30 calendar days of receipt. If the dispute concerns a fully insured plan participant, state law is followed if it is different from our standard policy. Notification of our decision will be sent to the health care professional within 45 days.

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 health care professional'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 on the basis of 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 hospital or facility failed to submit the request for review or arbitration within the required time frames.

Health Care Professional Termination Appeals

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

- A completed health care professional 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 health care professional 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 (Southern, IL) Illinois (Northern, 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)	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)	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 145 Centers of Excellence 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 600 transplant programs for organ and tissue transplantation committed to managing complex transplant procedures.

To be included in our Transplant Network, programs must meet our quality guidelines for experience, graft, and patient survival rates, as well as our transplant team training and experience requirements.

Each program is carefully reviewed to help ensure it meets the following standards:

- Minimum annual volumes for each transplant type to ensure an active and experienced transplant program
- One year graft and patient survival rates that are equal to or better than expected risk-adjusted rates as published on www.srtr.org
- Accreditations such as National Marrow Donor Program (NMDP) and Foundation for Accreditation of Cellular Therapy (FACT) for bone marrow/stem cell programs; and a CMS approved program
- Other criteria such as the experience of the transplant team personnel

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 a full-time dedicated medical director with a background 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 LifeSOURCE Transplant Network:

- Visit Cigna LifeSOURCE online at www.CignaLifeSOURCE.com. Here, you can find the list of Cigna LifeSOURCE participating facilities and information about our quality guidelines by clicking the "Our Network" tab.
- E-mail Cigna LifeSOURCE at LifeSOURCEweb@cigna.com.
- Call the Cigna LifeSOURCE Transplant Case Management Department at 1.800.668.9682.

Cigna Behavioral Health

Cigna Behavioral Health Participants Only

Cigna Behavioral Health, Inc. (CBH), our mental health and substance abuse company, provides benefits and case management services to most customers with medical benefits through Cigna. CBH offers a broad range of services that address the behavioral dimensions of health, disability, and workplace productivity.

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. CBH provides access to behavioral health services through a network of independently contracted health care professionals, behavioral health facilities, and chemical dependency facilities.

To arrange or confirm an inpatient referral or psychiatric consultation, please contact CBH 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. Additionally, advocates and care managers are available 24 hours a day for clinical emergencies.

For more information on CBH, or to find a participating health care professional, please visit our website at <http://apps.cignabehavioral.com/home.html>.

National Vendors

Durable Medical Equipment, Home Health and Home Infusion – CareCentrix

CareCentrix is the exclusive national provider of durable medical equipment (DME) and coordinator of homecare services.

Health care professionals can set up coordination of home care services through CareCentrix's credentialed provider network with one telephone call. For a "one-call" referral for home care services, please call 1.800.666.6127 or fax the orders for home services to 1.800.700.2085. This service is available 24 hours a day, 7 days a week, 365 days a year.

For a complete list of services and CPT codes that are covered by CareCentrix, please visit (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > CareCentrix DME HCPCS Codes).

CareCentrix will arrange for these services to be delivered directly to your patients. As part of this relationship, CareCentrix provides:

- Home health care (nursing, therapy services, social work, and home health aides)
- Home infusion products
- Home sleep services
- Insulin pumps and related supplies, continuous passive motion devices, wound suction devices, Pro time monitors, and DynaMaps
- DME (beds, standard wheelchairs, walkers, etc.)
- Respiratory equipment (oxygen, CPAP, ventilators)
- Enteral nutrition (pumps and nutritional support)
- Custom-powered wheelchairs and scooters

CareCentrix does not supply braces, orthotics, or prosthetics

Wheelchairs – CareCentrix

CareCentrix is Cigna's exclusive participating health care professional for wheelchair and scooter services. For more information on these services, please contact CareCentrix at 1.800.411.2305.

Fetal Monitoring – Alere

Alere is Cigna's exclusive participating health care professional for fetal monitoring. For more information on fetal monitoring, please contact Alere at 1.800.950.3963.

High-technology Radiology

MedSolutions is an advanced radiology benefit management company with a proven industry track record, dedication to quality, and dual national accreditation from the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC).

In most markets, we use MedSolutions to manage CT, MRI, and PET scans as well as Nuclear Cardiology services. For more information, call 1.800.88Cigna (882.4462) or MedSolutions at 1.888.693.3297.

When to call MedSolutions®

- For nuclear cardiology services: All states except Alaska and Hawaii
- For CT, MRI, and PET scans in the following markets: **All states** other than those listed below under “When to call Cigna”
- Health care professionals should follow the PHS/PHS+ guidelines
- Call 1.888.693.3211 or access MedSolutions online at cigna.medsolutionsonline.com

When to call Cigna

- For nuclear cardiology services in the following markets: Alaska and Hawaii
- For CT, MRI, and PET scans in the following markets: Alaska, Hawaii, Michigan (HAP service area ONLY) Minnesota, Montana, North Dakota, Upstate New York (MVP service area ONLY) and CareLink customers in Massachusetts and Rhode Island
- Health care professionals should follow the PHS/PHS+ guidelines
- Call the number on the back of the patient’s ID card to determine if authorization is required

The radiology coverage precertification process features improved customer service through the Informed Choice program. MSI may contact individuals with Cigna-administered coverage to inform them about the choices of available in-network radiology service providers. MSI can also explain the associated costs of the radiology services and can schedule services that are authorized for coverage at the radiology center selected by the patient. For more information about MedSolutions or the Informed Choice program, please visit www.medsolutions.com/implementation.

Access MediQuip

In some markets, Access MediQuip, Inc. (AMQ) provides exclusive implantable medical device management services for all surgical procedures that require implantable medical devices, including biologics, tissue, and bone.

AMQ is a national distributor of outsourced medical implantable device management solutions. They maintain approximately 1,200 relationships with medical facilities, and partner with 175 device manufacturers to provide more than 400,000 devices. AMQ also has an implantable device registry, which measures quality and safety outcomes and tracks devices, including any recalls that might occur years after an individual's surgery.

The original implementation began on June 1, 2010, and included ASCs in the following states:

- California
- Colorado
- Connecticut
- Michigan
- Missouri
- Nevada
- New Hampshire
- New York
- North Carolina
- South Carolina

Beginning April 12, 2013, this relationship includes certain ambulatory surgery centers (ASCs) in the following additional states:

- Arizona
- Louisiana
- Tennessee
- Wyoming
- Arkansas
- Mississippi
- Texas
- Georgia
- Montana
- Utah
- Florida
- Oregon
- Washington

What this relationship means to health care professionals

- ASCs will be able to work directly with AMQ to order the implantable device and coordinate the delivery of the surgical implant(s) to the surgical setting.
- The implant device carrying cost will be removed from the ASC because AMQ will assume the financial responsibility for implantable devices, and will bill us directly for the cost of the implant.
- The ordering physician's preference for the implantable device selection is preserved.
- AMQ will work directly with us to precertify the surgical implant(s) in accordance with our administrative guidelines and clinical coverage policies.
- AMQ will contract directly with the ASCs and other facilities and schedule on boarding sessions with them.

For more information on these services, please contact Access MediQuip at 1.877.985.4850.

Vision Service Plan (VSP)

Participants covered under Cigna administered plans may self-refer to a participating VSP health care professional for routine vision exams or primary eye care as allowed by their Cigna administered plan. If a Participant's benefit plan includes vision care, he or she may access a wide range of routine eye care services through VSP. To access vision care benefits, the Participant may contact a VSP participating health care professional to make an appointment. For help locating a VSP participating health care professional, call VSP at 1.800.877.7195. The website address for VSP is <https://www.vsp.com/>.

American Specialty Health (ASH)

ASH is responsible for chiropractic network management, utilization management and claims management services for patients with Cigna administered coverage.

ASH administers in-network chiropractic benefits for Cigna Commercial HMO, Network, POS, Open Access, and Open Access Plus medical benefit plans. ASH also reviews claims from non-participating chiropractors for medical necessity. Cigna will continue to administer the network for chiropractors participating in the Cigna-direct PPO network.

ASH will manage treatment after the initial evaluation is completed.

American Specialty Health (ASH)
P.O. Box 509001
San Diego, CA 92150-9001

For general inquiries, you can call ASH Provider Services Department at 1.800.972.4226.

Laboratory Services

By choosing a laboratory that participates in our network, you help ensure your patients receive the highest possible benefits under their Cigna plan, while limiting their out-of-pocket expenses.

We currently contract with laboratories that can offer you and your patients' quality services at cost-effective rates.

For a complete list of participating laboratories, visit Cigna.com > Health Care Professionals > Health Care Professionals Directory > Facility/Ancillary > Labs.

For many Cigna plans, referring patients to hospitals for ambulatory laboratory services may result in significantly higher out of pocket expenses – even if the hospital is a Cigna participating facility. Therefore, referring your patients to a preferred, independent reference laboratory can help ensure they maximize the benefits available to them through their plan.

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.

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 our automated telephone services at 1.800.88Cigna (1.800.882.4462) or GWH-Cigna network at 1.866.494.2111

If a participant does not have an ID card or enrollment form, call 1.800.88Cigna (1.800.882.4462) or the GWH-Cigna network at 1.866.494.2111.

Cigna makes no representations or guarantees about the number of participants referred to a health care professional. Cigna also reserves the right to direct participants to selected participating health care professionals and to influence participants’ choice of participating health care professional.

These tools do not guarantee eligibility.

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. An eligible Cigna participant may still present an ID card containing a SSN. 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 new identifiers begin with U0 (zero). In some cases, when entering the identification number the capital letter ‘O’ is being input instead of the numeral 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](#) or other EDI vendor
- Log in to the secure Cigna for Health Care Professionals website ([CignaforHCP.com](#)) > Patients > Search Patients or call 1.800.88Cigna (1.800.882.4462)

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 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 health care professional to obtain information that may help in the resolution of the concern or complaint. This also provides an opportunity for the health care professional to respond to the concern or complaint.

Health Care Professional Cooperation

A participant may ask for your assistance in regards 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 health care professional 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 Information

- Participant's treating health care professional, 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.

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 patients' 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 1.800.88Cigna (882.4462).

Cigna expects you to be compliant with HIPAA and other applicable 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. The compliance date for covered entities, with the exception of small health plans, was April 21, 2005. Small health plans were required to comply by April 21, 2006.

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

5010 Transaction Standards

In January 2009, the U.S. Department of Health and Human Services published final rules requiring the health care industry to upgrade electronic standard transactions under HIPAA to version 5010. The new rules apply to the health care industry—health plans, hospitals, doctors, and other health care professionals—and affects others who currently use HIPAA version 4010 to transmit data. The implementation date for version 5010 was January 1, 2012.

Important changes in version 5010:

- Claim and Encounter 837
- Electronic Remittance Advice (ERA) 835
- Eligibility and Benefit Inquiry and Response 270/271
- Claim Status Inquiry and Response 276/277

To learn more about changes Cigna made to comply with the 5010 Transaction Standards, go to [Cigna.com > Health Care Professionals > Resources for Health Care Professionals > Doing Business with Cigna > 5010 Transaction Standards](http://www.cigna.com/healthcareprofessionals/resources-for-health-care-professionals/doing-business-with-cigna/5010-transaction-standards.html) (<http://www.cigna.com/healthcareprofessionals/resources-for-health-care-professionals/doing-business-with-cigna/5010-transaction-standards.html>).

National Provider Identifier

The National Provider Identifier (NPI) is a unique identification number for use in standard health care transactions. The NPI is a number issued to health care professionals and covered entities that transmit standard HIPAA electronic transactions (e.g., electronic claims and claim status inquiries). As of May 2005, the Centers for Medicare and Medicaid Services (CMS) began issuing NPIs to health care professionals that apply and qualify.

The NPI fulfills a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and was required to be used by health plans and health care EDI vendors in HIPAA standard electronic transactions by May 23, 2007. In addition, the NPI:

- Replaces other identifiers previously used by health care professionals and assigned by payers (i.e., UPIN, Medicare/Medicaid numbers)
- Establishes a national standard and unique identifier for all health care professionals
- Helps simplify health care system administration and encourage the electronic transmission of health care information

Cigna is capable of accepting 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

- Required data elements such as the “Billing Provider” Taxpayer Identification Number (TIN), “Rendering Provider” name and “Billing Provider” address must always be included on professional, institutional, and dental claims. Inclusion of this information does not change because of NPI implementation.
- As with any change to your billing process, if you plan to change the way you submit claims to Cigna, refer to the [demographics](#) section of this guide to update your information. One example would be an organization that has enumerated multiple NPI sub-parts and will start to bill using the “lowest enumerated” subpart health care professional.
- When using the NPI to identify the “Billing Provider”, the TIN must be submitted as a secondary provider identifier. This TIN is the number used on the IRS Form 1099, which is either the employer identification number (EIN) for organizations or the social security number (SSN) for individuals. Both numbers should not be included concurrently. Other identifiers, such as the 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 the following:

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 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 than that of the “Billing Provider.”

Electronic Remittance Advice (835)

- In most instances, the “Billing Provider” (claim payee) NPI will be included on the 835. If more than one claim is included in a single 835. The NPI will be included in the 835 only if all NPIs from the submitted claims are equal. The NPI for the “Rendering Provider” will be included in the 835, if the “Rendering Provider” NPI was submitted on the claim.

Real-Time Request Transactions (270, 276, 278)

- All real-time request transactions will be accepted with NPI, Cigna will return the NPI when it was submitted on the inquiry. Contact your EDI vendor for details regarding the submission of NPI on these transactions.

Additional information is available on the Cigna website, Cigna.com (Health Care Professionals > Resources for Health Care Professionals > Doing Business with Cigna> [National Provider Identifier](#)).

Cigna Member Rights and Responsibilities for Customers

The following statement of participant rights and responsibilities is given or made available to customers when they enroll annually through our Commitment to Quality collateral, available on the participants' secure website. While states may mandate variations, the statement typically reads as follows.

You Have the Right to:

Receive coverage for the medical benefits and treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
Get understandable information 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 information about the qualifications of clinical staff that support Cigna wellness and similar programs.
Have access to a current list of in-network doctors, hospitals and places you may receive care and information about a particular doctor's education, training and practice.
Select a primary care doctor for yourself and each covered member of your family, and change your primary care doctor for any reason.
Have your medical information kept confidential by Cigna and your doctor. 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 professional in health decisions and have your health care professional give you information about your medical 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 made aware of any special Cigna programs or services available to assist you, as well as how to enroll or change programs or services. 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 care and disenroll from programs and services offered by Cigna. If you refuse medical care, your health care professional should tell you what might happen. We urge you to discuss your concerns about care with your primary care doctor or other participating health care professional. Your doctor or health care professional will give you advice, but you will have the final decision.
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 professionals 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.
Make recommendations regarding our policies that affect your rights and responsibilities. If you have recommendations, 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.
Show your ID card before you receive care.
Schedule a new patient appointment with any in-network primary care doctor; build a comfortable relationship with your doctor, ask questions about things you don't understand, and follow your doctor's advice. You should understand that your condition may not improve and may even get worse if you do not follow your doctor's advice.
Understand your health condition and work with your doctor to develop treatment goals that you both agree upon.
Provide honest, complete information to the health care professionals caring for you.
Know what medicine you take, why, and how to take it.
Pay all copayments 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 professional'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 professional.
Notify your plan administrator and treating health care professional as soon as possible about any changes in family size, address, phone number, or status with your health benefit plan or Cigna's programs and services.

Prescription Drug Program

This Information Pertains to Physicians and Other Health Care Professionals Only

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.

Cigna requires that generic equivalents be dispensed for brand-name drugs as available and appropriate in the clinical judgment of a physician. 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 Health Care Professionals Only

Participants who have a Cigna pharmacy benefit are enrolled in one of the following plans:

- Two-tier plan
- Three-tier plan
- Four-tier plan

Participants with Cigna ID Cards:

Participants in the two-tier prescription drug plan have coverage for prescription drugs included in the Cigna prescription drug list (PDL). Participants pay one copayment amount for generic or first-tier drugs and a slightly higher copayment for preferred brand-name or second-tier drugs that have no generic equivalent.

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-named drugs with no generic equivalent are typically considered second-tier drugs and have a slightly higher copayment; and drugs in the third-tier have the highest copayment. Third-tier drugs include brand names that have equally effective and less-costly generic equivalents or have one or more preferred brand-name options.

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-named drugs with no generic equivalent are typically considered second-tier drugs and have a slightly higher copayment. Drugs in the third tier include brand names that have equally effective and less-costly generic equivalents or have one or more preferred brand-name options and are covered at the third-tier copayment. The fourth-tier category consists of either self-administered injectables or therapeutic class options. There is also a four-tier plan design option that separates preferred brand drugs into two categories (second- and third-tier) and moves the non-preferred brand tier-three drugs into the fourth-tier category.

Prescription Drug Program

Participants with GWH-Cigna ID Cards:

Plan options are based on a variety of two-, three-, and four-tier plans. For a description of the specific plans, log in to CignaforHCP.com > Drug list.

Preventive Prescription Drug Option

Under some plans that have a deductible, participants may not be required to pay the deductible for preventive medications. The participant would only be responsible for the out of pocket cost, typically copayments or coinsurance. Preventive medications are those prescribed to prevent the occurrence of a disease or condition for those participants 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 within the online Drug Lists on Cigna.com.

If you have questions about our Prescription Drug Program, call 1.800.88Cigna (882.4462).

Prescription Drug List

This Information Pertains to Physicians and Other Health Care Professionals Only

- The Prescription Drug List (PDL) is a subset of the top drugs and therapeutic classes from the Cigna drug list. This preferred list of FDA-approved medications is the foundation of the Cigna prescription drug program. You may access the entire drug list online at CignaforHCP.com > Resources > Drug List, or request a paper copy by calling 1.800.88Cigna (882.4462).

If a requested prescription drug is not listed in the PDL and the participant has the two-tier closed drug list benefit, Cigna will review the request as an exception. Exceptions may include non-formulary drugs, precertification, step therapy, off label and early refills. You may request an exception by calling the pharmacy exception center at:

- Cigna ID cards: 1.800.Cigna24 (244.6224)
- GWH-Cigna ID cards: 1.866.265.6578.

Medications Requiring Precertification

Participating physicians and participating pharmacies in the Cigna network are responsible for following the Cigna Prescription Drug List (PDL) outpatient drug formulary. If a generic or preferred drug should not be prescribed in your medical judgment for a participant in a closed-formulary benefit plan, due to non-availability, or if the prescribed drug is one of the few medications on the PDL that require prior approval of coverage, you are required to contact the Cigna pharmacy service center to request precertification of coverage.

You have several options for submitting precertification requests. Participants in “open formulary” benefit plans such as three and four tier benefit plans do not have precertification requirements to obtain a drug in a non-preferred tier.

- | |
|---|
| <ul style="list-style-type: none">• Fax a completed prescription coverage request to:<ul style="list-style-type: none">– Cigna ID cards: 1.800.390.9745– GWH-Cigna ID cards: 1.866.960.7716 |
| <ul style="list-style-type: none">• Email your request to:<ul style="list-style-type: none">– Cigna ID cards: rxzfaxsys@cigna.com– GWH-Cigna ID cards : N/A |
| <ul style="list-style-type: none">• Call:<ul style="list-style-type: none">– Cigna ID cards: 1.800.Cigna24 (244.6224)– GWH-Cigna ID cards: 1.866.265.6578 |

All 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 a CignaforHCP.com > Resources > Pharmacy Resources > Communications > Prior Authorization Forms or CignaforHCP.com > Resources > Forms Center > Prescription Forms > General Prior Authorization.

Prescription Drug Program

Medications Typically Excluded from the Prescription Benefit

This Information Pertains to Physicians and Other Health Care Professionals Only

Cigna Participants:

Coverage for prescription drugs and related supplies is subject to the terms and conditions of a participant's benefit plan, including but not limited to the "exclusions and limitations" section of the benefit plan. The following are typically excluded from the prescription benefit:

Any drugs or medications available over the counter that do not require a prescription by federal or state law, and any drug or medication that has a chemical equivalent i.e. same active ingredient and equivalent dosage to an over the counter drug or medication other than insulin.
Medications that are therapeutically equivalent as determined by the Cigna Pharmacy and Therapeutics Committee in which at least one of the medications within the class is available over the counter. [examples include Rx equivalents to OTC Allegra, Claritin and Zyrtec (Allegra D, Clarinex, Xyzal) and Rx equivalents to OTC Prevacid, Prilosec, Zantac (Aciphex, Kapidex, Nexium, Axid, Pepcid, Zantac)]
Any injectable infertility medications, and any injectable medications that require Health Care Professional supervision and are not typically considered self-administered medications. The following are examples of Health Care Professional supervised medications: <ul style="list-style-type: none">• Injectables used to treat hemophilia and RSV (respiratory syncytial virus)• Chemotherapy injectables• Endocrine and metabolic agents
Any drugs that are experimental or investigational, within the meaning set forth in the Agreement.
Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is prescribed for the treatment of a life-threatening or chronic and seriously debilitating condition, the drug is Medically Necessary to treat that condition, and the drug has been recognized for treatment of that condition by one of the following: <ul style="list-style-type: none">• The American Hospital Formulary Service Drug Information• Two articles published in English language• Peer reviewed medical bio-medical journals that present data supporting the proposed off-label use or uses as generally safe and effective for the proposed indication.
Any prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances, except as covered in this Rider. Please refer to Definitions, Related Supplies, for covered supplies.
Any prescription vitamins (other than pre-natal vitamins), dietary supplements and fluoride products.
Prescription Drugs used for cosmetic purposes, such as, drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.

Prescription Drug Program

Any diet pills or appetite suppressants (anorectics) unless the participant's benefit plan includes this coverage.
Prescription smoking cessation products unless Medically Necessary unless the participant's benefit plan includes this coverage.
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 beyond two (2) incidents per Calendar Year. Each incident may include one or more prescriptions.
Medications used to enhance athletic performance.
Any medications used for treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido unless the participant's benefit plan includes this coverage
Medications which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
Prescriptions more than one year from the original date of issue.
Any infertility drugs or infertility injections, unless the participant's benefit plan includes this coverage.

Home Delivery Pharmacy Prescription Drug Program

This Information Pertains to Physicians and Other Health Care Professionals Only

Cigna Participants

Cigna provides a home delivery pharmacy benefit designed for participants with maintenance* medication needs. When participants use Cigna Home Delivery Pharmacy, they may have an opportunity to reduce their out-of-pocket costs by obtaining up to a 90-day supply of their maintenance medications in one fill. The 90-day supply maximum is subject to physician judgment and 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 automatically will be substituted unless you indicate "dispense as written." Participants or physicians may contact Cigna by calling 1.800.835.3784. Physicians may access information about Cigna Home Delivery Pharmacy online at CignaforHCP.com > Resources > Pharmacy Resources > Cigna Home Delivery Pharmacy.

**Maintenance medications are prescription drugs used to manage chronic or long-term conditions when participants respond positively to drug treatment and dosage adjustments.*

Specialty Pharmacy Prescription Drug Program

Physicians and Other Health Care Professionals Only

Cigna Specialty Pharmacy Management is the national preferred source for specialty medications and operates as a part of Cigna's wholly owned dispensing pharmacy, Cigna Home Delivery Pharmacy. Cigna Specialty Pharmacy Management dispenses specialty medications covered under the pharmacy and medical benefit. Cigna Specialty Pharmacy Management can provide most specialty pharmacy medications for a variety of therapeutic classes including injectable medications for the treatment of:

Anticoagulants	Blood modification	Endocrine / Metabolic conditions
Growth hormone deficiency	Hemophilia	Hepatitis C
Infertility	Joint degeneration	Multiple sclerosis
Rheumatoid arthritis	Plaque psoriasis	Respiratory syncytial virus
Cancer	Immune deficiency	Transplants
Cystic fibrosis		

Additionally, Cigna's Specialty Pharmacy Condition Specific Teams provide specialized assistance for patients. Conditions include Oncology, Fertility, hepatitis C, hemophilia (factor), Immune Globulin (Hizentra, Gammgard, Gammunex,), transplants, cystic fibrosis and human immunodeficiency virus (HIV), with plans to add inflammatory and autoimmune conditions and multiple sclerosis by end of 2013. Patient advocates provide patients with a thorough understanding of the process and help patients understand how to manage their condition, take their medication as indicated, and ensure they have access to all known resources for support. The Condition Specific Teams, which include registered nurses, proactively reach out to patients and anticipate their needs.

Cigna specialty medication prescription orders are shipped confidentially and delivered by first-class mail to the destination indicated on the prescription order form. Expedited carrier and special packaging is used for medications requiring refrigeration and overnight delivery at no additional charge.

Immunizations are not offered through the specialty pharmacy prescription program.

Cigna Specialty Pharmacy also offers a Clinical Infusion Program to support both patients and physicians. Clinicians provide patient education on lifestyle changes, medication administration, adherence education, and any anticipated infusion issues such as leakage, infusion rates, etc., following an initial prescription. Follow-up outreach is made 72 hours after the initial therapy to assess for infusion issues and adherence to treatment plan. The Cigna clinician will outreach to the patient's physician to determine if treatment plan will continue as written or if changes need to be made and help coordinate follow up activity.

Ordering from Cigna Specialty Pharmacy

Designed to simplify administrative requirements for you and your office staff, the Cigna Specialty Pharmacy Program makes ordering specialty pharmacy medications easy. When calling or faxing orders to Cigna Specialty Pharmacy Management, the pharmacy team will:

- Verify participant eligibility
- Obtain precertification and prior authorization, as applicable
- Facilitate coordination of care
- Bill Cigna directly
- Provide patient education materials and supplies when requested
- Facilitate financial assistance as needed and appropriate
- Coordinate shipping to physician or participant

Specialty Pharmacy Orders

Information on Cigna Specialty Pharmacy Management as well as the general injectable and medication-specific order forms can be found on Cigna.com > Health Care Professional > Pharmacy.

Contact Cigna Specialty Pharmacy Management for specialty and injectable medication prescriptions as follows:

New Orders

- Fax a completed general specialty and injectable medication fax order form to 1.800.351.3616.
- Telephone specialty and injectable medication prescription information to 1.800.351.3606.

Transfers

- Fax a completed general specialty and injectable medication fax order form to 1.800.351.3616 and indicate which pharmacy currently holds the prescription, including all necessary pharmacy contact information.
- Call 1.800.351.3606 and speak with a Cigna Specialty Pharmacy pharmacist to transfer the prescription.

A Cigna Specialty Pharmacy Pharmacist will review the order form and will coordinate with a centralized team to request precertification of coverage, when required.

Prescription Drug Program

Preferred Specialty Pharmaceutical List*

Cigna maintains a Preferred Specialty Pharmaceutical List. The decision of which drugs to prescribe is up to you based on your clinical judgment. Coverage is not limited to the preferred drug. All medications included on the list are available through Cigna specialty pharmacy.

Access the most current list, information on the program or download the Cigna medication order forms by logging in to Cigna.com > Health Care Professional > Pharmacy or by accessing the following link:

Cigna.com/customer_care/healthcare_professional/pharmacy/index.html.

To download the Cigna specialty pharmacy services drug specific fax order forms, log in to Cigna.com > Health Care Professional > Pharmacy or by accessing the following link: Cigna.com/customer_care/healthcare_professional/pharmacy/specialty_drug.html.

Growth Hormones	Hepatitis C Antivirals	Rheumatoid Arthritis Agents	Multiple Sclerosis Agents
Humatrope®	Pegasys®	Enbrel®	Avonex®
Saizen	**Peg-Intron®	Remicade®	Copaxone®
		Humira®	Rebif®

- Cigna reserves the right to make changes to this Preferred Specialty Pharmaceutical List without notice.
- Does not apply to participants with GWH-Cigna ID cards.

Coverage for Self-Administered Injectable Medications

A defined list of injectable medications are not covered under the Cigna medical plan but are covered under the Cigna Pharmacy Plan.

Medical plans that have implemented this benefit change will no longer cover the cost of these medications. In order to be covered under the Cigna Pharmacy Plan, these medications must be obtained from either a retail pharmacy or Cigna Specialty Pharmacy Management 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 your patient's pharmacy benefit is provided by a company other than Cigna, contact the pharmacy benefit company for information about coverage for these medications.

Prescription Drug Program

Self-administered injectable medications covered under a standard Cigna Pharmacy plan at the time of this publication are summarized below. If you have questions about the coverage of a certain medication, contact Customer Service at the telephone number on the patient's ID card.

Brand Name			
Actimmune	Apokyn	Arcalyst	Avonex
Betaseron	Cimzia SQ	Copaxone	Enbrel
Extavia	Fuzeon	Genotropin	Humatrope
Humira	Increlex	Infergen	Kineret
Norditropin	Norditropin Nordiflex	Omnitrope	Pegasys
Pegintron	Pegintron Redipen	Rebif	Relistor
Saizen	Serostim	Simponi	Somavert
Tev-Tropin	Xolair	Zorbtive	Firazyr
Sylatron	Sylatron 4-Pack	Egrifta	Pegasys Proclick
Norditropin Flexpro	Nutropin	Nutropin AQ	Nutropin AQ Nuspin
Egrifta	Stelara	Orencia SQ	

Does not apply to participants covered by a capitated risk group that has accepted responsibility for injectable medications. Actual coverage is subject to the terms of the particular participant's benefit plan.

Cigna Specialty Pharmacy Management Offers Drug Therapy Management

TheraCare® is a support program for Cigna customers who use specialty medications for certain chronic conditions.

TheraCare provides added support to customers to help them better understand their condition, medications, side effects, and the importance of taking their medication as prescribed. Medication adherence can lower the risk of side effects and improve the effectiveness of the medication. We have found in many cases, that patients' health and quality of life are improved when they comply with their treatment plan.

If the customer has any of the following conditions and uses a specialty medication for it, they may be eligible for TheraCare:

- Ankylosing spondylitis
- Asthma
- Cancer: oral oncology agents
- Crohn's disease
- Enzyme disorders
- Erythropoietins
- Growth hormone deficiency
- Hemophilia
- Hepatitis C
- Multiple sclerosis
- Psoriasis
- Psoriatic arthritis
- Pulmonary arterial hypertension
- Respiratory syncytial virus
- Rheumatoid arthritis
- Ulcerative colitis

Prescription Drug Program

Patients identified for program participation are contacted via telephone by Therapy Support Coordinators who educate them on the program and encourage their participation. Patients who agree to participate are enrolled in TheraCare and can participate in a series of telephone and mail outreach conducted by Therapy Support Coordinators and Registered Nurses (RNs).

The outreach includes educating the patient about their condition(s), their medication(s) and potential side effects, and ongoing monthly calls. Throughout therapy, the program monitors for prior authorizations that are set to expire and facilitates the re-authorization process with the goal of avoiding gaps in therapy approval and risk for non-adherence. Pharmacists are also available for patient consultation when needed.

Who is eligible? To be eligible for TheraCare a participant needs to be covered by an employer health benefit plan that has elected to offer the program to their employees and dependents. To determine if your patient has access to TheraCare, please call the TheraCare team at 1.800.633.6521.

What are the benefits for my patient? There are many benefits to your patient when they choose to participate in TheraCare. We take an integrated approach to care by focusing on the patient's total health, not just the specialty condition. After joining TheraCare, your patient will be assigned a personalized team, consisting of a therapy support coordinator and nurse, who will:

- Monitor your patient's side effects and help them to work through them
- Help your patient to reduce any roadblocks standing in the way of taking their medication as you prescribed
- Coordinate new prescription orders and refills through Cigna Home Delivery Pharmacy
- Assess adherence for appropriate laboratory monitoring of the disease
- Organize in-home training for your patient on how to use their self-injectable medications if needed

We understand your professional medical judgment is most important in the treatment of your patient. Our goal is to work collaboratively with you to maximize your patient's treatment by providing an added level of support and anticipating their needs. With the patient's consent, we will contact you with any concerns we have while working with your patient.

How will the TheraCare team work with me? The TheraCare program will work collaboratively with you to help your patient maximize outcomes from the therapy you prescribe. If any issues are identified by the TheraCare team, you will be notified.

How do I contact the TheraCare team? The TheraCare team can be reached at 1.800.633.6521, Monday through Friday, between 10:00 am and 9:00 pm Eastern time. Our [Cigna websites](#) inform you and your patients when they are eligible for TheraCare services. The information presented is specific to the patient's plan design.

- Your patients with Cigna coverage that are eligible to participate in TheraCare can find information about the program on the "My Plans – Pharmacy" screen of [myCigna.com](#).
- [myCigna.com](#) also has a new section on the Pharmacy page under Additional Resources highlighting the TheraCare program, if available to that patient.
- In addition, the Cigna for Health Care Professionals website ([CignaforHCP.com](#)) has a section specific to Specialty Pharmacy Management to inform you whether medications require prior authorization under the pharmacy benefit and what specialty network is available to your patient.

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 health care professionals and hospitals to facilitate more informed decision-making by the participants we serve.
- Evaluate participant and health care professional 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 1.800.88Cigna (1.800.882.4462).

Cigna invites our contracted health care professionals 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 in our Clinical Care Guidelines below.

Clinical Care Guidelines

This Information Pertains to Physicians and Other Health Care Professionals Only

Clinical care guidelines, as outlined below, may be used as a resource as you screen and treat various conditions:

- **A Guide to Cigna's Preventive Benefits for Health Care Professionals**
Cigna.com/customer_care/healthcare_professional/medical/care_guidelines.html
- **Clinical guidelines for behavioral health**, including depression, attention-deficit and hyperactivity disorder and alcohol screening
<http://apps.cignabehavioral.com/web/basic/site/provider/treatingBehavioralConditions/treatingBehavioralConditions.jsp>

Quality Management Program

- **Chronic Condition Management** (Cigna's Disease Management Program) adopted clinical practice guidelines from nationally recognized professional societies 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 > Clinical Health And Wellness Programs > Chronic Condition Management, or call 1.800.88Cigna (1.800.882.4462) to request a paper copy.

- **Cigna Well Aware for Better Health Disease Management**, including depression, asthma, diabetes, cardiovascular disorders, heart failure, chronic obstructive pulmonary disease, and other targeted conditions. Please visit <http://www.healthways.com/CignaWeb/home/ProviderPrograms.asp> for other guidelines or call 1.800.88Cigna (1.800.882.4462) to request a paper copy.

Peer Review

This Information Pertains to Physicians and Other Health Care Professionals Only

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 and Behavioral Continuity and Coordination of Care

This Information Pertains to Physicians and other Health Care Professionals Only

To facilitate continuous and appropriate care for participants, and to strengthen industry-wide continuity and coordination of care among medical practitioners and physicians, the quality program monitors, assesses, and may identify opportunities for participants or physicians to take action and improve upon continuity and coordination of care across health care network settings and transitions in those settings. Assessment of continuity and coordination of care collaboration may include, but is not limited to, measurement of the following as demonstrated using surveys, committee discussions reflected in minutes, medical record review, and data analysis. Examples of monitoring may include:

- Exchange of information in an effective, timely, and confidential manner.
- Notification and movement of participants from a terminated practitioner.
- Monitoring of participants who qualify for continued access to a practitioner terminated for other than quality reasons.
- Encouraging participants to forward copies of their medical records to their new primary care physician (PCP) when PCP changes are made.

Quality Management Program

Following are examples of what may be collected and measured, but are not inclusive of the types of data that may be collected by Cigna Quality Management staff to evaluate continuity and coordination of care:

- Home Health Start of Care Timeliness
 - Percentage of Home Health Cases Started when appropriate
- Emergency Department (ED) Care and Primary Care Physician Sites
 - Percentage of Cigna customers experiencing ED re-admissions due to lack of follow up with their Primary Care Physician.
- Customer Outreach Following Discharge from an Inpatient Facility
 - Percentage of post-hospital discharged Cigna customers completing a return visit with Primary Care Physician or specialist as appropriate
- Ambulatory Medical Record Review Continuity of Care Indicators
 - Specialist and Ancillary Consultations are reviewed by Primary Care Physicians
 - Labs and Diagnostics are reviewed by Primary Care Physicians
 - Adverse Event and Quality of Care Complaint Monitoring with root cause of continuity and coordination of care to identify trends or individual interventions required

Based upon conclusions for each monitor, Cigna will communicate results and analysis to practitioners and facilities if opportunities for improvement are identified.

Behavioral and Medical Continuity and Coordination of 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 communication between behavioral and medical practitioners.
- Appropriate health care professional screening, treatment and referral of behavioral health disorders commonly seen in primary care.
- Evaluation of the appropriate uses of psychopharmacological 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.

Ambulatory Medical Record Review (AMRR)

This Information Pertains to Physicians and Other Health Care Professionals Only

As part of our Quality Improvement Program, and in select markets as required by state regulation, Cigna selects a random sample of participating primary care physicians. 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 AMRR are as follows:

- Determine the structural integrity and irretrievability of medical records
- 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

Medical records are randomly selected for review from physicians and for participants who have been enrolled in Cigna for a minimum of six months, and who have had a minimum of two visits 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 physicians.

For information on medical record best practices, please visit CignaforHCP.com > Resources > Medical Resources > Commitment to Quality.

Pharmacy and Therapeutics Review

This Information Pertains to Physicians and Other Health Care Professionals Only

Cigna uses a National Pharmacy and Therapeutics (P&T) Committee. Committee participants include practicing physicians and clinical pharmacists from local markets across the U.S., Cigna medical and pharmacy directors, and outside pharmacology consultants. The committee meets quarterly 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 Pharmacy and Therapeutics Committee is an evidence-based approach to clinical literature. A comprehensive drug monograph is prepared by an external university-based drug information service and presented to the committee.

Through the Pharmacy and Therapeutics 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 newly Federal and Drug Administration (FDA) approved drugs receive a determination of Non Preferred until P&T Committee review can be held. The P&T Committee reviews priority approvals, as designated by the FDA, within six (6) months of their approval or launch to the market.

Non-priority designated FDA approvals are reviewed after at least six (6) months from the FDA approval or market launch to allow for additional post marketing publications regarding a drug's clinical efficacy or safety to be evaluated. The Prescription Drug List generally considers any non-excluded 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 on non-clinical factors such as cost.

Clinical and Quality Improvement Studies

This Information Pertains to Physicians and Other Health Care Professionals Only

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 select physician specialties and hospitals, and provide this information to individuals in order to help facilitate more informed decision-making when they select physicians and hospitals for the provision of their care. We may provide performance feedback to help you assess and enhance performance around:

- Quality of care
- Quality of service
- 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 health care professional directory and includes:

- Recognition for participation in National Quality Initiatives such as Leapfrog for Hospitals and the National Committee for Quality Assurance (NCQA) Recognition for Physicians
- Provider Excellence Recognition Directory
- Hospital Value Tool including identification of Centers of Excellence
- Physician Profiles
- Cigna Care Designation

Additional information detailing our methodology for physician 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 was formed by a group of Fortune 500 companies with the goal of improving patient safety in hospitals. Through the annual **Leapfrog Hospital Survey**, hospitals across the country are rated on a range of quality and safety practices that should be employed by all hospitals. Leapfrog ratings are posted on the Leapfrog website and are free to the public. This effort focuses on the following safety practices endorsed by the National Quality Forum (NQF) including:

- Computer Physician Order Entry (CPOE) – computerized medication order entry
- Staffing Intensive Care Units (ICUs) with Physician Intensivists
- Evidence-based hospital referrals – referring patients needing certain complex medical procedures to hospitals offering the best survival odds
- Leapfrog Safe Practices Score – progress toward the above three safe practices and 27 additional high-priority safety practices based on the National Quality Forum Safe Practices for Better Health Care

The Leapfrog Group maintains a public online database including data voluntarily submitted by hospitals. For more information about the Leapfrog Group, go to www.leapfroggroup.org. Hospitals completing the Leapfrog Hospital Survey are listed in the Cigna Provider Excellence Recognition Directory at <http://Cigna.benefitnation.net/cignams/default.asp>.

National Quality Forum

The National Quality Forum was established to facilitate health care quality improvement by designing a national quality of care measurement and reporting system and endorsing national health care quality performance measures. The National Quality Forum has endorsed a set of national voluntary consensus standards for hospital care performance measures and ambulatory care measures. We encourage all health care professionals 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.

Hospital Quality Alliance (HQA) – National Voluntary Hospital Reporting Initiative

The American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges developed the National Voluntary Hospital Reporting Initiative to encourage hospitals to begin voluntarily reporting quality information and make the information publicly available. This initiative is an excellent opportunity to inform patients that your hospital is committed to improving quality of care. More information is available at www.aha.org.

Quality Management Program

National Committee for Quality Assurance (NCQA) Physician Recognition Program

NCQA's voluntary Physician Recognition Programs recognize high-performing physicians and practices in key areas of clinical quality and care coordination. Physicians may attain recognition in any of the below Recognition Programs:

- Diabetes
- Heart and stroke
- Physician Practice Connections
- Physician Practice Connections-Patient Centered Medical Home

Recognition of National Quality Initiatives

Cigna recognizes hospital and physician participation in these national quality initiatives through its WebMD Hospital AdvisorSM hospital selection tool, online Provider Excellence Recognition Directory, and incorporation of participation in these programs in its hospital and physician evaluation programs.

Provider Excellence Recognition Directory

The Cigna Provider Excellence Recognition Directory publicly recognizes participating physicians who have achieved recognition from the National Committee for Quality Assurance (NCQA) and participating hospitals that fully meet one or more of the Leapfrog patient safety standards.

To access the directory, go to <http://Cigna.benefitnation.net/cignams/default.asp>.

Prescription Drug Program

Cigna Care® Designation and Physician Profiles

This information pertains to physicians and other health care professionals only

We annually evaluate physician quality and cost-efficiency information. By using a methodology that is consistent with national standards and incorporating physician feedback, we are able to provide individuals with relevant information through Cigna Care Designations and Physician Quality and Cost-Efficiency Displays.

Available in 69 service areas, the designation distinguishes physicians in 22 specialty types and multispecialty groups that participate in the Cigna network, based on specific quality and cost-efficiency measures. Cigna Care designated physicians are identified in the online health care professional directory on Cigna.com and myCigna.com by a unique symbol.

Cigna Care Network is a benefit plan design option that is offered to organizations that sponsor group health benefit plans. The benefit design, intended to encourage participants covered by these plans to consider using a Cigna Care designated physician, affords a lower copayment or coinsurance for services provided by a Cigna Care designated physician than if they select a participating, non-designated physician.

Please note that overall physician reimbursement is unchanged as a result of this program.

Quality and Cost-Efficiency Displays

The Cigna Physician Quality displays are available on both the public and secure websites at Cigna.com and myCigna.com, while cost-efficiency displays are available only on the secure myCigna.com website. The displays are available for 69 markets for 22 specialty types.

Symbols are assigned to physicians and physician groups indicating the quality criteria met, while two or three stars are used to illustrate cost-efficiency. Three stars for cost-efficiency represents the top one third of physicians and physician groups when compared to their specialty peers within the market. Two stars represent groups falling between 2.5 percent and 67 percent, and one star represents groups in the bottom 2.5 percent for cost-efficiency.

The displays reflect a partial assessment of quality and cost-efficiency, and should not be the sole basis for decision-making as such measures have a risk of error. Individuals are encouraged to consider all relevant factors and to consult with their treating physician when selecting a physician for care.

Requests for reconsideration or additional information

Participating physicians and physician groups have a right to correct errors and request data review for both the Cigna Care designation and Physician Quality and Cost-Efficiency displays.

To review additional quality and cost-efficiency information, obtain a full description of the methodology and data that our decisions were based on, correct inaccuracies, request that we reconsider specific results, or to submit additional information, health care professionals should email us at PhysicianEvaluationInformationRequest@Cigna.com or

Quality Management Program

fax requests to 1.866.448.5506. 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.

Hospital Value Tool and Centers of Excellence

The Hospital Value Tool and Centers of Excellence program was developed to provide individuals with information to aid them in their health care decision-making. This information is a partial assessment of hospitals and should not be used as the sole basis for decision-making. Individuals are encouraged to consider all relevant information and to consult with their treating physician in selecting a hospital.

We have profiled 31 surgical procedures and medical conditions for both Patient Outcomes and Cost-Efficiency. Patient Outcomes are measures of a hospital's relative effectiveness in treating the selected procedure or condition, while Cost-Efficiency is a measure of a hospital's cost (not including physicians' fees and outpatient services) compared to other hospitals nationally.

The data used to profile these procedures and medical conditions are hospital self-reported, public information from Medicare (MedPar) or, where available, participant states (All Payer) as provided by HealthShare Technology/WebMD.

Participating hospitals receive a score of one, two, or three stars each for both Patient Outcomes and Cost-Efficiency measures for each of the 31 procedures and conditions, as well as an overall score. For each procedure or condition evaluated, hospitals that attain a total score of five stars for both Patient Outcomes (up to three stars) and Cost-Efficiency (up to three stars) receive our Center of Excellence designation for that procedure or condition.

Additional detail about our methodology can be found at Cigna.com/CentersOfExcellence. If you have further questions, please call 1.800.88Cigna (1.800.882.4462).

Preventive Care

Cigna Participants Only

Cigna has updated its preventive care coverage to comply with the Patient Protection and Affordable Care Act (PPACA). Services designated as preventive care include periodic well visits, routine immunizations and certain designated screenings for symptom-free or disease-free participants. Preventive care services also generally include additional immunization and screening services for symptom-free or disease-free participants at increased risk for a particular disease.

The PPACA requires that non-grandfathered health plans cover preventive care services with no cost sharing. Most Cigna plans cover the full cost of preventive care services for participants with Cigna coverage, including copay and coinsurance. There are some exceptions.

Quality Management Program

To determine if your patient's Cigna administered plan covers preventive care at 100%, visit the Cigna for Health Care Professionals website (CignaforHCP.com) to verify benefit and eligibility information, or call 1.800.88Cigna (882.4462). For patients with a GWH-Cigna or Great-West Healthcare ID card, visit the GWH-Cigna Secured Provider Portal (GWHCignaforHCP.com), or call 1.800.663.8081.

Preventive Care Services

The PPACA has designated specific resources that identify the preventive services required for coverage by the Act. These resources are below:

- 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. Recommendations of the ACIP appear in four immunization schedules
- Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA). Comprehensive guidelines for infants, children, and adolescents supported by HRSA 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 for additional preventive services for women were released in August 2011 and become effective for non-grandfathered plans upon renewal date occurring on or after August 1, 2012. These additional services, not already addressed by the USPSTF, are:
 - Well-woman visits
 - Gestational diabetes screening
 - HPV DNA testing in combination with Pap smear
 - STI counseling
 - HIV screening and counseling
 - Contraception and contraceptive counseling
 - Breastfeeding support, supplies (including breastfeeding equipment. and counseling
 - Interpersonal and domestic violence screening and counseling

Coding for Preventive Services

Correctly coding preventive care services is key to receiving accurate payment for those services.

- Preventive care services need to be submitted with an ICD-9 code that describes encounters with health services that are not for the treatment of illness or injury.
- These diagnosis codes need to be identified as the primary diagnosis code on the claim form.

Quality Management Program

- If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service will not be identified as preventive care and your patients' claims will be paid using their normal medical benefits rather than enhanced preventive care coverage.

Modifier 33: Preventive Service Modifier

Modifier 33 was created in response to the preventive service requirements associated with the PPACA. When the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect, and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending modifier 33, preventive service, to the procedure code.

Modifier 33 should be used only for services represented by codes which may be used for either diagnostic, therapeutic or preventive services, in order to indicate that the service was used for the preventive indication.

- Important Note: Our claim systems are not yet configured to process preventive service claims solely based on the use of modifier 33. Therefore It is required that the service also be submitted with a well-person diagnosis code as indicated previously in this guide. We will notify health care professionals when our claim systems can accept and recognize modifier 33.

For additional information about preventive health coverage, please see "A Guide to Cigna's Preventive Health Coverage for Health Care Professionals" located at:

http://Cigna.com/customer_care/healthcare_professional/medical/care_guidelines.html or Cigna.com/health/provider/medical/care_guidelines.html.

Participants with GWH-Cigna ID cards

Patients with GWH-Cigna ID cards have preventive service coverage for periodic physical exams performed by a health care professional. This includes:

- X-ray and lab services if part of the annual physical exam
- Necessary immunizations and booster shots.

The Plan covers:

An annual pelvic exam	Pap smear and mammogram
Colorectal cancer screening	Prostate specific antigen

Preventive care x-rays and lab tests ordered as part of an office visit are subject to the X-rays and Lab Tests "Preventive Care" payment percentage shown in Open Access Plus Medical Benefits Summary.

Cigna Well Informed – Bridging Gaps in Care

Purpose of the Cigna Well Informed Program

Well Informed is a clinically based program that analyzes patients' medical, laboratory, and pharmacy claim data against evidenced-based medical standards to proactively identify potential omissions or gaps in care.

Quality Management Program

Well Informed provides actionable information to health care professionals to help manage patients' care, increase their engagement in their own health, and improve patients' outcomes by identifying potential omissions or gaps in care. Well Informed can help to:

- Identify potential adverse drug reactions
- Identify prescriptions and services provided by other physicians that could affect treatment plans
- Alert physicians of potential divergence from common or accepted standards of care
- Support physicians in chronic disease management
- Increase patient compliance with treatment plans
- Encourage patients to be involved and informed about their health status and actions they may take to delay disease progression

How Well Informed Works

- Well Informed addresses disease prevention and focuses on more than 30 chronic illnesses and acute conditions [e.g., diabetes, chronic obstructive pulmonary disease (COPD), hypertension, depression, high cholesterol].
- Patient data is reviewed monthly to identify potential gaps.

Well Informed communicates this information to health care professionals and their patients whenever a potential issue is identified:

- Health care professionals are mailed a clinical data profile for any patient identified as having a potential gap in care. This profile may assist health care professionals in determining whether to initiate any interventions or adjust existing treatment plans.
- For patients with certain Cigna coverage, the same information is shared with the clinical staff of our medical management programs, including case management, chronic condition management, health advocacy coaching, and pharmacy. This information helps our clinical staff reach out to patients more successfully, increasing the effectiveness of our medical programs. Well Informed does not include this feature for patients with a GWH-Cigna ID card.

For further information on Well Informed, please log in to the secure Cigna for Health Care Professionals website (CignaforHCP.com).

3 Star Quality Bariatric Center

This information pertains to physicians and other health care professionals only

We assess bariatric surgery facilities to include in the online health care professional directory as 3 Star Bariatric Centers

3 Star Bariatric Centers

Facilities and doctors are reviewed for 3 Star Quality designation by meeting the standards set forth by the Surgical Review Corporation (SRC). SRC is an independent, nonprofit organization governed by industry stakeholders and dedicated to advancing the safety, efficacy, and efficiency of bariatric and metabolic surgical care worldwide.

The standards are based on education, training, experience, facility capabilities, and outcomes. Listed facilities and doctors also need to be contracted as part of the Cigna network. Cost efficiency is not a criterion in the certification process. The 3 Star Quality review process is ongoing, and the information is updated periodically throughout the year. Surgeons practicing at 3 Star Quality Bariatric Centers receive Bariatric Surgeon "B" designation in the online health care professional directory. The 3 Star Bariatric Centers can be found on the Cigna.com and myCigna.com websites.

If you are currently a participating health care professional in the Cigna network and have a comprehensive bariatric surgery program at your facility, we welcome the opportunity to learn more about your program and to evaluate it for possible designation as a 3 Star Quality Bariatric Center.

Requirements to qualify for this designation include:

- Level 1 Full Approval from the [American College of Surgeons \(ACS\) Bariatric Surgery Center Network \(BSCN\)](http://American College of Surgeons (ACS) Bariatric Surgery Center Network (BSCN)); and/or
- Full Approval from the Surgical Review Corporation (SRC) (www.surgicalreview.org/); and
- Active status as a participating health care professional in the Cigna network; and
- Compliance with Cigna's established clinical outcomes criteria.

For more information, visit Cigna.com > Resources for Health Professionals > Health & Wellness Programs > Certification for Bariatric Surgery

Cigna Offers "Virtual House Calls" Through RelayHealth®

Cigna Participants Only

Cigna's partnership with RelayHealth® began as a pilot when Cigna became an early adopter of RelayHealth's secure physician and patient online communication tool. On January 1, 2008, Cigna HealthCare and RelayHealth expanded their four-state pilot program nationwide to provide increased access to secure online messaging that enables "virtual house calls." "Virtual house call" services include reimbursable webVisit®, online prescription refills and renewals, laboratory results, and the ability to schedule appointments.

What is a "virtual house call?"

A "virtual house call" is a consultation that uses an online, structured interview format to communicate patient symptoms to the physician. The physician can respond online, by telephone, or if necessary, request an in-office visit. "Virtual house calls" offer a more convenient and cost-effective way for patients to contact physicians for non-urgent, routine health issues.

What is the cost to health care professionals?

The cost ranges from **approximately \$25 to \$100 per physician per month** – depending on which, and how many, RelayHealth modules the physician purchases. Modules include administrative, ePrescription, and clinical.

What online services are available, and how do patients and health care professionals access these services?

RelayHealth services are available through the RelayHealth website, and do not require any additional software besides a web browser. Cigna plan participants have access to this website through the secure myCigna.com. Services include:

- **webVisit Online Consultation:** webVisit can guide your patient through an interactive interview, help them send a concise message to you, and provide you with an array of tools to efficiently reply.
- **eScript® Electronic Prescribing:** This electronic prescribing service enables you and your staff to instantly transmit prescriptions to virtually any pharmacy in the U.S. and automatically screen for possible drug interactions.
- **The Online Office:** This communications tool set may be used for common communications and transactions, such as scheduling appointments, refilling prescriptions, requesting referrals, and reviewing lab results.

Are these services secure?

Yes. Embedded Secure Sockets Layer (SSL) technology – a protocol that delivers server authentication, data encryption, and message integrity – ensures messages can only be read by the registered health care professional, their authorized staff, and the patient. No Protected Health Information (PHI) flows by regular email, which is used only to notify patients of an awaiting message.

What is the cost to my patients?

Your patients covered by a Cigna copayment plan can expect to pay the same copayment as an in-office visit, while those with coinsurance plans may actually pay less than an in-office visit. Appropriate copayments, coinsurance, and deductibles will be applied.

How are health care professionals reimbursed for a service like the webVisit?

The American Medical Association (AMA) has established a permanent CPT-4 code, 99444, to enable reimbursement for online physician consultations. Cigna reimburses for these services at \$25 per webVisit (copayments and deductibles apply). The RelayHealth service verifies the patient eligibility at the point of service, collects applicable payments from the patient, and submits the medical claim to Cigna on your behalf. You will receive collected patient payments from RelayHealth and medical benefit payments from Cigna in the same manner you receive your other Cigna claim payments.

Are health care professionals that participate in RelayHealth identified in the health care professional directory?

Yes. Health care professionals that participate in RelayHealth are displayed with a webVisit notation in the online Provider Directory on myCigna.com and Cigna.com. If you would like to see a sample listing, search for Dr. "Keating" near ZIP code 06002.

How do my patients and I participate in the online services available through RelayHealth?

Your patients should register for RelayHealth online through the secure myCigna.com. All patients interested in using the RelayHealth service will need to have an existing relationship with a RelayHealth participating health care professional prior to consulting with a physician online.

There are two ways for health care professionals to join RelayHealth:

- Go to <https://app.relayhealth.com/Registration.aspx>
- Call RelayHealth customer service at 1.877.744.9682

Cigna has agreed to waive the subscription fee for the first three months of enrollment for participating health care professionals that are not part of a larger medical group and who enroll through the website.

Cigna's 24-Hour Health Information Line

The majority of Cigna's medical 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 or downloaded.
- Assistance in locating contracted physicians, hospitals, ancillaries or other health care professionals, even when outside the normal service area.

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.

Healthy Babies[®] Program

By providing access to a wealth of maternity-related information and resources, the Cigna Healthy Babies program helps women achieve healthy pregnancies. The Healthy Babies program is a collection of Cigna maternity benefits and an educational mailing, available to Cigna customers as part of their Cigna medical benefit plan.

Participants receive an educational mailing including a Welcome Kit. The Welcome Kit contains a spiral bound notebook that provides information on topics including prenatal care, reducing risk factors, fetal development, and newborn care.

Participants also have access to the March of Dimes website and toll-free number, and around-the-clock access and support through Cigna's Health Information Line.

The program 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.

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 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 rate. This is accomplished through the following initiatives:

- Preconception planning and education
- Infertility education and shared decision-making tools
- 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 health care professionals
- 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 through the use of incentive payments to participants upon completion of the program. Once referred, 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.

All program participants receive a Welcome Kit upon enrollment. The Welcome Kit includes a notebook with a journal, calendar, link to the March of Dimes[®] website, and other helpful tools to track and help maintain a healthy pregnancy.

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 pain 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,

Cigna Cancer Support

Cigna Cancer Support, our robust oncology program, is available to people enrolled in some of Cigna's health plans. 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 and his or her physicians.

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 risk assessment responses and laboratory results. Additionally, the program integrates with Cigna's online health assessment, 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 integration helps facilitate referrals between programs and the appropriate exchange of information.

Our cancer care specialists are nurses who have oncology expertise and competencies, and are part of a dedicated, centralized team. Oncology physicians also support the program.

Cancer Support nurses work with participants at various levels of acuity (stratification). These nurses can assist participants in the following ways:

- 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.

Quality Management Program

- Provide direct links to national cancer sites, such as the National Cancer Institute, the National Comprehensive Care Network (NCCN), WebMD® Cancer Information Center, the University of Texas MD Anderson Cancer Center, and Cancer Control PLANET sites.
- Help participants navigate the complex health care system and minimize the administrative hassles of claim payment, benefit, and authorization issues.
- 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. Cancer Support nurses 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 (formerly known as Disease Management Program)

Cigna administers two programs that address chronic disease conditions. Patients may be eligible for one of these two programs, but not both.

Your Health First®

Our whole person solution weaves all the health issues affecting a chronic participant into one ongoing conversation. Cigna's Your Health First solution provides health management tailored to each participant's preferences. And it is all delivered through the continuous, personalized support of a dedicated health advocate. These advocates:

- Support participants with their 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 Your Health First is to help participants improve the quality of their lives and overall health. Your Health First is a primary advocate model; once a participant and health advocate relationship is formed, the health advocate remains that participant's health advocate for any future needs or concerns.

Using a rules-based priority algorithm, we identify participants who may benefit from participation in these programs on a monthly basis based on medical, pharmacy and laboratory claims, as well as health assessment results. We contact these individuals to encourage participation in coaching based on their opportunity risk score and stage of condition. We also identify potential program participants through physician, medical management, pharmacy and other health advocacy referrals, as well as individual self-referrals. We strive to deliver advocate-supported, proactive contact for those identified with a potential chronic condition.

Quality Management Program

Your Health First contacts potential participants for coaching for the following 16 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		

Coaching is not limited to specific conditions and their co-morbidities. When a participant with a chronic condition that is not listed in the above conditions contacts the program, Cigna health advocates will provide chronic condition coaching or refer the participant to another more appropriate resource or program.

Supported by evidence-based medical guidelines and the most influential behavioral techniques, our health advocates help 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. In addition to telephone coaching, online self-directed assistance is also available.

From a physician's perspective, the Cigna team is a resource to help facilitate compliance with the treatment plan that has been created to aid in recovery and 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-physician relationship by helping to prepare participants to have meaningful and educated interactions with their treating physicians and other members of their health care team.

To view information on Chronic Condition Management, log in to the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Medical Resources > Clinical Health And Wellness Programs > Chronic Condition Management.

Information includes:

Cigna Well Aware for Better HealthSM

The Cigna Well Aware for Better HealthSM chronic condition management program is a population-based, patient-centered solution developed to address the needs of participants with chronic conditions. Developed in cooperation with participating physicians based on their needs and experiences, the program can provide valuable tools designed to help facilitate the delivery of quality care. The program serves as a complementary medical resource that supports participants throughout the year and helps to make visits with their physicians more productive.

The suite of Well Aware programs addresses more than 30 chronic conditions. The program can provide individualized education and support for participants with the following chronic conditions:

Asthma	Chronic obstructive pulmonary disease	Depression
Diabetes	Heart disease	Low back pain
Weight complications	Targeted conditions	

The program can provide education and support for the following 15 targeted medical conditions:

Growth hormones	Hepatitis C antiviral	Infertility agents
Acid-acid reflux disorders	Atrial fibrillation	Decubitus ulcer
Crohn’s disease	Dyspepsia	Esophagitis
Hepatitis C	Fibromyalgia	Inflammatory bowel disease
Irritable bowel syndrome	Osteoporosis	Osteoarthritis
Peptic ulcer	Ulcerative colitis	Urinary incontinence

This Information Pertains to Physicians and Other Health Care Professionals Only

Cigna identifies participants who may benefit from the Well Aware program and sends program materials to participants and physicians.

When your patients with Cigna benefits participate in the Well Aware program, you can receive:

- Patient-specific medication reports
- Quarterly condition-specific newsletters
- Well Aware care guides based on national clinical practice guidelines
- Patient-specific compliance reports twice a year
- Patient-specific notification of positive depression screening (with patient’s permission, available only by mail)

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- Information on recognizing depression in patients with chronic conditions
- Other patient-specific information, as appropriate

Additional details about our Chronic Condition Management programs are available on your health care professional website (CignaforHCP.com). Information includes:

- Detailed program description with reference to how we identify, stratify, and engage our chronic condition participants
- The evidence based guidelines used for each condition of our programs. Our guidelines are reviewed at a minimum biannually on a rolling schedule. These routine updates occur quarterly on the health care professional website. Health Alert bulletins are available immediately if there are important evidence based content changes.
- Supporting program materials
- Opportunity care outreach, including timelines
- Cigna's standard complaint process and other feedback
- Practitioner rights when working with Cigna and our programs
- Hours of operation and contact information, including telephone number, website, and email address if applicable

Cigna's Health Advocacy Programs

Cigna defines “health advocacy” as proactive, personalized, and integrated health support and coaching services 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 the University of Michigan Health Management Research Center Health Assessment. Through the health assessment and the supporting Trend Management System (TMS), with its application of sophisticated underlying analytics, we can help people recognize and address potential health risks. The health assessment process evaluates each participant’s health assessment responses to help identify those who may benefit from enrollment in various health programs. When responses show a participant’s health risk in the areas of nutrition, physical activity, sleep or stress, they are immediately invited to participate in an online coaching program to address that topic. Additionally, after the health assessment responses are analyzed, all participants receive a health assessment profile that contains easy-to-understand information specific to their own health risks, which they are encouraged to share with their health care professionals.

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, the program provides an integrated look at a participant's risk for any of six health and wellness topics in order to assess the benefits of a contact call and telephone coaching. The six topic areas: hypertension, hyperlipidemia, prevention, 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 discussion points to discuss with you as they work with you to come to a treatment decision.

The program's health advocates also contact participants when potential gaps related to hypertension or hyperlipidemia are identified. Health advocates use the data to coach participants for whom a potential gap in care related to these or other areas 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 both telephone 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, interactive tools, and discounts 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, deal 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 registered nurses, health educators, and other specialists, provides the health advocacy coaching that is included in our Health Advisor program. They also provide medical case management services to program participants. 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.

Cigna clients may elect to combine Your Health First chronic condition coaching with health advocacy programs, including Cigna Health Advisor, the Personal Health Team, and the Lifestyle Management Programs.

Integrated Personal Health Team

The Integrated Personal Health Team (IPHT) consists of co-located specialists who work together to deliver an enhanced customer experience and promote positive behavior change and overall health improvement. With this customer-centric model, a health advocate is appointed for each participant who becomes their primary health advocate for all future events or concerns. Our most integrated model, the IPHT model brings together the following services:

- Personal Health Solutions (PHS) or PHS+ core medical management

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- Health Advisor coaching
- Lifestyle Management coaching
- Your Health First chronic condition coaching (Please see the Your Health First section for detailed information about this component.)
- EAP and behavioral health solutions

IPHT delivers an integrated, customer-centric model that helps eliminate barriers to health improvement by focusing on the participant and his or her multiple needs addressed by one person, not through independent programs.

As with all of our programs, clients may choose to include Cigna's Pharmacy services or our disability services to effect an even greater integration for our clients and customers.

Healthcare Effectiveness Data and Information Set (HEDIS®)

This Information Pertains to Physicians and Other Health Care Professionals Only

Healthcare Effectiveness Data and Information Set (HEDIS) measures are standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on, and improving the quality of care provided by managed care organizations. HEDIS is designed to help ensure purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS also includes the Consumer Assessment of Healthcare Providers and Systems (formerly Consumer Assessment Health Plan Study) (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 also may 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. The data collection process occurs from February through May of each year and is obtained from claim and encounter data administrative systems. However, to help capture an accurate and comprehensive reflection of the care provided to participants, Cigna also audits a sampling of medical records for some measures. The records for HEDIS are requested and generally received by fax or mail. Your cooperation is essential to the success of the HEDIS program.

A letter will be sent to your office with a list of participants and the information required. Please fax or mail the requested information. A follow-up telephone call may be necessary if additional information is needed. Cigna also has the ability to access your electronic medical records remotely if you utilize a medical record system that supports web-based access.

A Cigna representative will contact your office to arrange the review process. Once the on-site review is scheduled, you will receive a list of participant names and the measures selected for the review process. If the list consists of a few participants, you may be asked to mail or fax the required information. During the review, Cigna will copy only those portions of selected medical records that include relevant information.

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Participants in the review are selected through a random sampling process stringently outlined by NCQA. All identifying information is kept confidential. Your provider agreement provides for the release of medical record information to Cigna for these quality projects without specific patient permission. Review the guidelines on the HIPAA website at <http://www.cms.hhs.gov> if you have questions or concerns.

*HEDIS® is a registered trademark of NCQA

HEDIS® Medical Record Review

This Information Pertains to Physicians and Other Health Care Professionals Only

The following standards are part of the record documentation and review process.

HEDIS review auditors require copies of the actual medical record.
Time frames are very specific. Requested records are for the prior year or earlier.
Participant names should appear clearly on the documentation.
Participant name changes due to marriage, divorce, adoption, etc. should be clearly documented in the medical record.
Complete dates (mm/dd/yy) 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. Request a copy of the school vaccine administration record and/or a copy of the previous PCP immunization history.
For colorectal cancer screening, document the date when the diagnostic procedure was performed, and the results. Obtain the actual diagnostic reports for your records.
For patients being monitored due to hypertension, document the diagnosis of hypertension and date, if known, in the patient's medical history and/or in the problem list.
Obtain all ophthalmologist or optometrist reports for dilated retinal exams for patients with diabetes. Ensure that results of the exam are clearly indicated in the report.
Include the actual lab results in the medical record.
For pediatric well-care visits, document dates of well-care visit(s) and physical(s), and any evidence of ongoing issues.

HEDIS® 2013 Measures

This Information Pertains to Physicians and Other Health Care Professionals Only

HEDIS or the Healthcare Effectiveness Data and Information Set is a core set of approximately 70 performance measures developed by the National Committee on Quality Assurance (NCQA) in collaboration with clients and health plans. The following are the detailed performance standards for key measures.

Prevention and Screening	
Adult BMI Assessment (ABA)	
The percentage of customers 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year before the measurement year.	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.	
<ul style="list-style-type: none"> • BMI percentile documentation*. • Counseling for nutrition. • Counseling for physical activity 	
Childhood Immunization Status (CIS)	
The percentage of children who had the recommended immunizations by their second birthday. The following 19 rates are produced:	
<ul style="list-style-type: none"> • Four DTaP vaccinations (DTaP) • Three polio vaccinations (IPV) • One measles, mumps, rubella vaccination (MMR) • One hepatitis A vaccinations (HepA) • Three hepatitis B vaccinations (HepB) • Combo Two – All of the above vaccinations except: PCV, HepA, RV and flu • Combo Three – All of the above vaccinations except: HepA, RV and flu • Combo Four – All of the above vaccinations except: RV and flu • Combo Five– All of the above vaccinations except: HepA and flu 	<ul style="list-style-type: none"> • Three H influenza type B vaccinations (HiB) • Two influenza vaccinations (flu) • One chicken pox vaccination (VZV) • Four pneumococcal conjugate vaccinations (PCV) • Two or Three rotavirus vaccinations (RV) • Combo Seven – All of the above vaccinations except: flu • Combo Eight – All of the above vaccinations except: RV • Combo Nine – All of the above vaccinations except: HepA • Combo Ten – All of the above vaccinations

<ul style="list-style-type: none"> • Combo Six – All of the above vaccinations except: HepA and RV
<p>Immunizations for Adolescents (IMA) The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their thirteenth birthday. The measure calculates a rate for each vaccine and one combination rate.</p>
<p>Human Papillomavirus Vaccine for Female Adolescents (HPV) The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.</p>
<p>Breast Cancer Screening (BCS) The percentage of women ages 40–69 years of age who had a mammogram during the measurement year or the year before the measurement year.</p>
<p>Cervical Cancer Screening (CCS) The percentage of women 21–64 years of age who received one or more Pap tests during the measurement year or the two years before the measurement year.</p>
<p>Colorectal Cancer Screening (COL) The percentage of customers 51–75 years of age who had appropriate screening for colorectal cancer.</p>
<p>Chlamydia Screening in Women (CHL) The percentage of women 16–24 years of age who were identified as sexually active who had at least one test for chlamydia during the measurement year.</p>
<p>Glaucoma Screening in Older Adults (GSO) The percentage of Medicare customers 65 years and older, without a prior diagnosis of glaucoma or glaucoma suspect, who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions. (Medicare Only)</p>
<p>Care for Older Adults (COA) The percentage of adults 66 years and older who had each of the following during the measurement year (Medicare Special Needs Plans Only):</p> <ul style="list-style-type: none"> • Advance care planning • Medication review • Functional status assessment • Pain screening
<p>Respiratory Conditions</p>
<p>Appropriate Testing for Children with Pharyngitis (CWP) The percentage of children 2–18 years of age, diagnosed with pharyngitis, dispensed an antibiotic and who received a group A streptococcus test for the episode. A higher rate represents better performance (e.g., appropriate testing).</p>
<p>Appropriate Treatment for Children with Upper Respiratory Infection (URI) The percentage of children three months to 18 years of age given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the diagnosis date.</p>

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Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

The percentage of customers 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis.

Pharmacotherapy Management of COPD Exacerbation (PCE)

The percentage of COPD exacerbations for customers 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1 – November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

- Dispensed a systemic corticosteroid within 14 days of the event
- Dispensed a bronchodilator within 30 days of the event

Use of Appropriate Medications for People with Asthma (ASM)

The percentage of customers 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Medication Management for People With Asthma (MMA)

The percentage of customers 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

- The percentage of customers who remained on an asthma controller medication for at least 50 percent of their treatment period
- The percentage of customers who remained on an asthma controller medication for at least 75 percent of their treatment period

Asthma Medication ratio (AMR)

The percentage of customers 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Cardiovascular

Cholesterol Management for Patients with Cardiovascular Conditions (CMC)

The percentage of customers 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1 – November 1 of the year before the measurement year, or who had a diagnosis of Ischemic Vascular Disease (IVD) during the measurement year and the year before the measurement year, who had each of the following during the measurement year:

- LDL-C Screening
- <LDL-C Control (<100mg/dl)

<p>Controlling High Blood Pressure (CBP) The percentage of customers 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.</p>
<p>Persistence of Beta Blocker Treatment After a Heart Attack (PBH) The percentage of customers 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI), and who received persistent beta-blocker treatment for six months after discharge.</p>
<p>Diabetes</p> <p>Comprehensive Diabetes Care (CDC) The percentage of customers 18–75 years of age with diabetes (type 1 or type 2) who had each of the following:</p> <ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing • HbA1c control (<7.0%) for a selected population • HbA1c control (<8.0%) • HbA1c poor control (>9.0%) • Medical attention for nephropathy • Eye exam (retinal) performed • LDL-C screening • LDL-C control (<100 mg/dL) • Blood pressure control (<140/80 mm Hg) • Blood pressure control (<140/90 mm Hg)
<p>Musculoskeletal</p> <p>Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART) The percentage of customers diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).</p>
<p>Osteoporosis Management in Women Who Had a Fracture (OMW) The percentage of women 67 years of age and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture. (Medicare Only)</p>
<p>Use of Imaging Studies for Low Back Pain (LBP) The percentage of customers with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, and CAT scan) within 28 days of the diagnosis.</p>
<p>Behavioral Health</p> <p>Antidepressant Medication Management (AMM) The percentage of customers 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported:.</p> <ul style="list-style-type: none"> • <u>Effective Acute Phase Treatment.</u> The percentage of newly diagnosed and treated customers who remained on an antidepressant drug for at least 84 days (12 weeks).

- Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated customers who remained on an antidepressant medication for at least 180 days (six months).

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication (ADD)

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- Initiation Phase: The percentage of customers 6–12 years of age as of the Index Prescription Start Date (ISPD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
- Continuation and Maintenance (C&M) Phase: The percentage of customers 6–12 years of age as of the ISPD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.

Follow-Up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for customers six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the customer received follow-up within 30 days of discharge.
- The percentage of discharges for which the customer received follow-up within seven days of discharge.

Medication Management

Annual Monitoring for Patients on Persistent Medications (MPM)

The percentage of customers 18 years of age and older who received at least a 180-day supply of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Four rates and a total rate are reported:

- Annual monitoring for participants on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for participants on digoxin
- Annual monitoring for participants on diuretics
- Annual monitoring for participants on anticonvulsants
- Total rate (sum of the four numerators divided by the sum of the four denominators)

Medication Reconciliation Post-Discharge (MRP) - Medicare Special Needs Plans Only

The percentage of discharges from January 1 to December 1 of the measurement year for customers 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)

The percentage of Medicare customers 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication, concurrent with or after the diagnosis. **(Medicare Only)**

Report each of the three rates separately and as a total rate.

- A history of falls and a prescription for tricyclic antidepressants, antipsychotics, or sleep agents
- Dementia and a prescription for tricyclic antidepressants or anticholinergic agents
- CRF and prescription for nonaspirin NSAIDs or Cox-2 Selective NSAIDs
- Total rate (the sum of the three numerators divided by the sum of the three denominators)

Customers with more than one disease or condition may appear in the measure multiple times (e.g., in each indicator for which they qualify). A lower rate represents better performance for all three rates.

Use of High-Risk Medications in the Elderly (DAE) - Medicare Only

- The percentage of Medicare customers 66 years of age and older who received at least one high-risk medication.
- The percentage of Medicare customers 66 years of age and older who received at least two different high-risk medications.

For both rates, a lower rate represents better performance.

Measures Collected Through the CAHPS Health Plan Survey

Aspirin Use and Discussion (ASP) – Medicare Only

The two components of this measure assess different facets of aspirin use management:

Aspirin Use

A two-year rolling average represents the percentage of participants who are currently taking aspirin. A single rate is reported for which the denominator includes:

- Women ages 56-79, with at least two risk factors for cardiovascular disease
- Men 46-65, with at least one risk factor for cardiovascular disease
- Men 66-79 regardless of risk factors.

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<p>Discussing Aspirin Risks and Benefits</p>	<p>A two-year rolling average represents the percentage of customers who discussed the risks and benefits of using aspirin with a doctor or other health professional. A single rate is reported for which the denominator includes:</p> <ul style="list-style-type: none"> • Women 56-79 • Men 46-79
<p>Flu Shots for Adults Ages 50–64 (FSA)</p> <p>A two-year rolling average represents the percentage of customers 50–64 years of age who received an influenza vaccination between September 1 of the measurement year and the date on which the survey was completed.</p>	
<p>Flu Shots for Older Adults (FSO)</p> <p>The percentage of Medicare customers 65 years of age and older as of January 1 of the measurement year who received an influenza vaccination between September 1 of the measurement year and the date on which the Medicare CAHPS survey was completed. (Medicare Only)</p>	
<p>Medical Assistance With Smoking and Tobacco Use Cessation (MSC)</p> <p>The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:</p> <ul style="list-style-type: none"> • <u>Advising Smokers and Tobacco Users to Quit:</u> A two-year rolling average represents the percentage of customers 18 years of age and older who are current smokers or tobacco users, who received cessation advice during the measurement year. • <u>Discussing Smoking Cessation Medications:</u> A two-year rolling average represents the percentage of customers 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. • <u>Discussing Smoking Cessation Strategies:</u> A two-year rolling average represents the percentage of customers 18 years of age and older who are current smokers or tobacco users, who discussed or were provided cessation methods or strategies during the measurement year. 	
<p>Pneumonia Vaccination Status for Older Adults (PSU)</p> <p>The percentage of Medicare 65 years of age and older as of January 1 of the measurement year who have ever received a pneumococcal vaccine. (Medicare Only)</p>	

Access/Availability of Care
<p>Adults Access to Preventive/Ambulatory Health Services (AAP)</p> <p>The percentage of customers 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.</p> <ul style="list-style-type: none"> • Medicaid and Medicare customers who had an ambulatory or preventive care visit during the measurement year. • Commercial customers who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year <p>Four rates are reported:</p> <p>■ 20-44 years ■ 45-64 years ■ 65 years and older ■ Total Rate</p>
<p>Children and Adolescents Access to Primary Care Practitioners (CAP)</p> <p>The percentage of customers 12 months–19 years of age who had a visit with a PCP. Four rates are reported:</p> <ul style="list-style-type: none"> • Children 12-24 months who had a visit with a PCP during the measurement year. • Children 25 months-6 years who had a visit with a PCP during the measurement year. • Children 7-11 years who had a visit with a PCP during the measurement year or the year before the measurement year. • Adolescents 12-19 years who had a visit with a PCP during the measurement year or the year before the measurement year.
<p>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)</p> <p>The percentage of adolescent and adult customers with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ul style="list-style-type: none"> • <u>Initiation of AOD Treatment</u>: The percentage of customers who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. • <u>Engagement of AOD Treatment</u>: The percentage of customers who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
<p>Prenatal and Postpartum Care (PPC)</p> <p>The percentage of deliveries of live births between November 6 of the year before the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:</p> <ul style="list-style-type: none"> • <u>Timeliness of Prenatal Care</u>: The percentage of deliveries that received a prenatal care visit as a participant of the organization in the first trimester or within 42 days of enrollment in the organization. • <u>Postpartum Care</u>: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

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Well-Child Visits in the First 15 Months of Life (W15)

The percentage of customers who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:

- No well-child visits
- One well-child visit
- Two well-child visits
- Three well-child visits
- Four well-child visits
- Five well-child visits
- Six or more well-child visits

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

The percentage of customers 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

Adolescent Well-Care Visits (AWC)

The percentage of enrolled customers 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Legal Statement

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