MEDICARE-MEDICAID PLAN (MMP)

Provider In-service
AGENDA

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- Cigna-HealthSpring CarePlan Exclusions
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- Claims/Appeals/Payment Disputes
- Nursing Facility Claims Process
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- Legal Obligations: ADA Requirements
- Fraud, Waste and Abuse
- Cultural Competency
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- Provider Website
- Important Phone Numbers
- Questions and Answers
Based in Nashville, Tennessee, Cigna-HealthSpring got its start in 2000 and is now one of the country’s largest and fastest-growing coordinated care plans whose primary focus is Medicare Advantage plans. Cigna-HealthSpring currently owns and operates Medicare Advantage plans in Alabama, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Mississippi, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, and Washington, D.C. as well as a national stand-alone prescription drug plan.

Our Mission Statement

Cigna-HealthSpring is dedicated to improving the health of the communities we serve by delivering the highest quality and greatest value in healthcare benefits and services.
Medicaid STAR+PLUS – Cigna-HealthSpring currently offers STAR+PLUS and Nursing Facility services in the Tarrant, Hidalgo and MRSA Northeast Service Delivery Areas.

Combined, Cigna-HealthSpring covers a total of 50 counties across the State of Texas providing these services.
The Texas Health and Human Services Commission (HHSC) proposed a new way to serve people who are eligible for both Medicare and Medicaid, known as dual eligible. The goal of the project is to better coordinate the care those individuals receive.

The Texas plan involves a three-party agreement between a Medicare-Medicaid health plan, the state and the federal Centers for Medicare and Medicaid Services (CMS) to provide the person with the full array of Medicaid and Medicare services.

The project provides an innovative payment and service delivery model to improve coordination of services for dual eligible members, enhance quality of care and reduce costs for both the state and the federal government.

March 1st, 2015, Cigna-HealthSpring began serving dual eligible beneficiaries in the Medicare-Medicaid Program in Hidalgo County. Our plan is referred to as Cigna-HealthSpring CarePlan.

Skilled Nursing Facility services began October 1, 2015.
Cigna-HealthSpring CarePlan Overview & Objectives

• Make it easier for clients to receive quality care.

• Promote independence in the community.

• Eliminate cost shifting between Medicare and Medicaid.

• Achieve cost savings for the state and federal government through improvements in care and coordination.

• Require one health plan to be responsible for the full array of services between Medicare and Medicaid.
Cigna-HealthSpring CarePlan Qualifications

Clients must meet the following criteria:

- MMP is offered in the following five counties: Bexar, Dallas, El Paso, Harris, and Hidalgo. Cigna-HealthSpring is participating in Hidalgo county.
- Are age 21 or older.
- Get Medicare Part A, B and D, and are receiving full Medicaid benefits.
- Enrolled in the Medicaid STAR+PLUS program, which serves Medicaid clients who have disabilities, or get STAR+PLUS Home and Community Based Services waiver services.
• The program will not include clients who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions or individuals with developmental disabilities who get services through one of these waivers:
  – Community Living Assistance and Support Services (CLASS)
  – Deaf Blind with Multiple Disabilities Program (DBMD)
  – Home and Community-based Services (HSC)
  – Texas Home Living Program (TxHmL)

• Other eligible individuals who may opt to enroll, include:
  – Individuals in a Medicare Advantage plan not operated by a health plan participating in the demonstration
  – Individuals in the Program of All-Inclusive Care for the Elderly (PACE)

• Clients who do not have third party insurance
Cigna-HealthSpring CarePlan Enrollment

• Members have the option to opt in or out on a monthly basis.

• To enroll or disenroll, members can call the Medicaid Enrollment Broker Maximus at 1-877-782-6440 or Medicare at 1-800-MEDICARE.
Cigna-HealthSpring CarePlan Benefits

Benefits

• Medicare Advantage Program benefits (Acute)
  – Medical
  – Behavioral (Medicaid covers some additional Behavioral Health services)
  – Part D

• STAR+PLUS Community Based Long Term Care benefits (LTSS)

• Cigna-HealthSpring Value-Added benefits

• Skilled Nursing Facility
Medically necessary services covered under the traditional and fee-for-service with Medicare and Medicaid program include:

- ambulance
- audiology
- chiropractic
- dialysis
- DME
- emergency services
- hospital services
- laboratory
- podiatry
- primary care services
- prenatal care
- radiology
- specialty care services
- therapies
- transplantation
- in-home telemonitoring
- skilled nursing

For a comprehensive list of services and/or exclusions, please refer to our current Cigna-HealthSpring CarePlan Provider Manual located on our website [http://www.cigna.com/medicare/healthcare-professionals/tx-mmp](http://www.cigna.com/medicare/healthcare-professionals/tx-mmp).
Cigna-HealthSpring CarePlan Benefits

Program Benefits (Behavioral)

Behavioral Health services – for the treatment of mental, emotional, or chemical dependency is a key component of the Cigna-HealthSpring CarePlan program. For a comprehensive list of covered behavioral health services and/or exclusions, please refer to the current Cigna-HealthSpring CarePlan Provider manual.

Examples include:

• Psychological Testing
• Electroconvulsive Therapy
• Mental Health Rehabilitative Services
• Targeted Case Management
• Supported Employment
• Residential services including
• Inpatient and Outpatient mental health services for adults & children
• Psychiatry services
• Health and Behavior Assessment and Intervention Services (HBAI)
## Cigna-HealthSpring CarePlan Benefits

### Value-Added Benefits – for Members in the community

<table>
<thead>
<tr>
<th>Service</th>
<th>Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in a Nursing Facility</th>
<th>Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in the Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-Health Information Line</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Extra Help Getting a Ride</td>
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<td>Yes</td>
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<tr>
<td>Extra Vision Services</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Extra Dental Services for Adults (age 21 and older)</td>
<td>Yes</td>
<td>Yes</td>
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<td>Hearing Services</td>
<td>Yes</td>
<td>Yes</td>
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<td>Drug Store Services</td>
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<td>Home Visits</td>
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<td>Extra Help for Pregnant Women</td>
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<td>Yes</td>
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<td>Emergency Response Services (ERS)</td>
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<td>Yes</td>
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<tr>
<td>Health and Wellness Services</td>
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<td>Yes</td>
</tr>
<tr>
<td>Gift Programs</td>
<td>Yes</td>
<td>Yes</td>
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</table>

**Note:** For more information on Cigna-HealthSpring CarePlan Value-Added benefits, please see the Cigna-HealthSpring CarePlan Member website at [http://www.cigna.com/sites/careplantx/index.html](http://www.cigna.com/sites/careplantx/index.html) or our Provider Manual at [http://www.cigna.com/medicare/healthcare-professionals/tx-mmp](http://www.cigna.com/medicare/healthcare-professionals/tx-mmp). Or contact Provider Service or Service Coordination.
Interacting with Cigna-HealthSpring CarePlan

Cigna-HealthSpring CarePlan Example ID Card

Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan)
Name: <Member Name>
Member ID: <Member ID>
Health Plan (80840)
Medicaid ID: <Member Medicaid ID>
PCP: <Provider Name>
PCP Effective Date: <PCP Effective Date>
PCP Phone: <Provider Phone #>
RxBIN: <017010>
RxPCN: <CHSCARE>
H8423-001

Website/Sitio web: www.careplantx.com
<barcode>

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir cuidado, llame a su PCP dentro de 24 horas o lo antes posible.
Member Services/Servicios al miembro: <1-877-653-0327>
Behavioral Health/Salud del comportamiento: <1-877-725-2539>
Service Coordination/Coordinador de servicios: <1-877-725-2688>
Hearing Impaired/Personas con problemas de la audición: <711>
For Prior Authorization/De autorización previa: <1-877-562-4402>
Pharmacy Help Desk: <1-844-265-1770>
Send pharmacy claims to: <P.O. Box 20002, Nashville, TN 37202>
Send Medical claims to: <P.O. Box 981709, El Paso, TX 79998-1709>
Claims inquiry: <1-877-653-0331>

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Interacting with Cigna-HealthSpring CarePlan

Prior Authorization

Network Limitations

Cigna-HealthSpring CarePlan does not require referrals from PCPs to in-network Specialty Care Providers or Ancillary providers.

- Members may select a PCP or one will be assigned to them. Members may see a Specialty Care Provider within the Cigna-HealthSpring CarePlan network.

- Female Members may seek obstetrical and gynecological services from any participating OB/GYN without a referral from her PCP.

- Cigna-HealthSpring CarePlan is a strong supporter of a PCP medical home. We highly encourage members to seek an evaluation from their PCP prior to seeing a specialist as often times the PCP can meet the member's medical needs.
Prior Authorization

• Prior Authorization is a component of the Utilization Management Department and issues authorizations for those services that require prior authorization as defined by Cigna-HealthSpring CarePlan. Utilization Management Department is responsible for issuing authorizations based on plan benefit coverage, eligibility at the time services are rendered and medical necessity.

• A list of services requiring Prior Authorization can be found in the Cigna-HealthSpring CarePlan Provider Manual and our website, http://www.cigna.com/medicare/healthcare-professionals/tx-mmp. All inpatient admissions, all Out of Network services and all LTSS services require Prior Authorization.

• If a Member is admitted to an inpatient facility, Utilization Review nurses obtain initial clinical information during the Member's stay through discharge. The UM nurse is responsible for authorizing any services/equipment needed to ensure a safe discharge. The UM nurses communicate admission and discharge information to the Service Coordinators assigned to the member.
Interacting with Cigna-HealthSpring CarePlan

Prior Authorization

Cigna-HealthSpring CarePlan highly recommends Members access care through their PCP. If the PCP determines that specialty care, diagnostic testing, or other ancillary services are required, the PCP should refer the Member to an in-network provider. Cigna-HealthSpring CarePlan is an open-access plan and does not require referrals. Providers should refer members to in-network providers. Out-of-network providers require an authorization.

The list of Prior Authorization Services is intended to provide an overview of services requiring authorization. If a Member requires a service that is not listed in the Provider Manual or website, the provider should contact the Utilization Review team to inquire about the need for prior authorization. The presence or absence of a procedure or service on the list does not determine a Member's coverage or benefits.

*Failure to obtain prior authorization for services that require authorization may result in nonpayment of services. It is important to note that prior authorization does not guarantee payment.*
Limits of Authorization

Providers may request authorization up to 30 in advance of the service. If the service is authorized, but not provided for more than 30 days of the authorization, another authorization request with new clinical information is recommended as the member’s condition may change. For our LTSS providers, services for Personal Attendant Services, Day Activity, and Health Services authorizations are usually issued for a 12 month period, but may be reassessed as needed. With the addition of the Medicare-Medicaid Plan, Skilled Nursing Facilities admissions will be authorized based on medical necessity using InterQual criteria. CMS benefit limits will apply.

Out-of-Network Referrals

If a service is not available within Cigna-HealthSpring's CarePlan provider network, a PCP may refer out-of-network or out of the service area. Prior to referring out-of-network or out of the service area, the PCP should document the justification for out-of-network services and obtain prior authorization from Cigna-HealthSpring CarePlan. All non-emergent, out-of-network services require prior authorization.
Prior Authorization Process

To initiate the prior authorization process, providers should follow the procedures listed below.

1. The provider evaluates a Cigna-HealthSpring CarePlan Member and determines that a "prior authorization service" is required.

2. At least five (5) business days prior to the requested date of service, the provider completes a Texas Standard Authorization Form, which is found on our website. The provider should include all pertinent clinical information supporting the need for the requested service, such as, results of any diagnostic tests or laboratory services results.

3. The provider faxes the completed form to Cigna-HealthSpring CarePlan.
4. A prior authorization request is reviewed by a nurse who completes the medical necessity screening. It may be necessary to collect additional information from the ordering provider, such as clinical information, that is necessary to make the decision.

5. Cigna-HealthSpring will fax the authorization letter along with the authorization number and approved codes/services back to the requesting provider. The authorization number can be used when billing for the approved service.

6. A request may be denied for the following reasons:
   – There was not enough clinical information to provide a sound determination.
   – There was an in-network provider available to provide the services.
   – The request for authorization does not meet medical necessity requirements.

The ordering provider will be notified of the denial by fax and/or phone. The Cigna-HealthSpring CarePlan Member will be notified of the denial in writing if the member is still inpatient or services have not yet been rendered.
3 Ways to Request Prior Authorization:

1. Fax a Prior Authorization Form to
   1-877-809-0787 (Any Outpatient service)
   1-877-809-0786 (Inpatient)
   1-877-809-0788 (LTSS)

2. Request Prior Authorization through the secure Provider Portal

3. Call 1-877-725-2688 and speak with a representative

Note: Prior Authorization Forms may be found on Cigna-HealthSpring's CarePlan provider website http://www.cigna.com/medicare/healthcare-professionals/tx-mmp (select the appropriate hyperlink).
The Texas Standard Prior Authorization Request Form for Health Care Services.

(Additional option)

- Member name and identification number;
- Location of service e.g., hospital or surgery center setting;
- PCP/requesting provider name;
- Servicing physician name and NPI;
- Date of service;
- Diagnosis;
- Service/Procedure/Surgery description and CPT or HCPCS code; and
- Clinical information supporting the need for the service to be rendered.

Cigna-HealthSpring CarePlan reviews requests made via fax or portal after hours, weekends and holidays.
## Interacting with Cigna-HealthSpring CarePlan

### Prior Authorization

#### Authorization Time Frames

<table>
<thead>
<tr>
<th>ACUTE</th>
<th>LTSS</th>
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<tbody>
<tr>
<td>Standard In-Network</td>
<td>Personal Attendant Service (PAS)- 3 Days</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Day Activity Health Service (DAHS)- 3 Days</td>
</tr>
<tr>
<td>Expedited</td>
<td>Respite Care/Adult Foster Care- 3 Days</td>
</tr>
<tr>
<td>Emergency Admissions &amp; Services – Not Required</td>
<td>Assisted Living / Residential Care- 3 Days</td>
</tr>
<tr>
<td>Post-Stabilization Request- Within 1 hour</td>
<td>Emergency Response Service (ERS)- 3 Days</td>
</tr>
<tr>
<td></td>
<td>Medical Supplies- 3 Days</td>
</tr>
<tr>
<td></td>
<td>Minor Home Modifications- 14 Days</td>
</tr>
<tr>
<td></td>
<td>Supported/Employment Assistance - 3 Days</td>
</tr>
<tr>
<td></td>
<td>Cognitive Rehabilitation Therapy - 3 Days</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Facility - will be authorized based on medical necessity using InterQual criteria. CMS benefit limits will apply.</td>
</tr>
</tbody>
</table>
Laboratory

Authorizations Required

- All other labs except
  1. Quest
  2. CPL
  3. ProPath
  4. LabCorp

Authorizations NOT Required

- See Next Slide for complete list of labs that DO NOT require Authorization
**Authorizations NOT Required**

**Note: All other labs should be sent to Quest, LapCorp, CPL and ProPath**

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>81001</td>
<td>Urinalysis nonauto w/ scope</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis nonauto w/o scope</td>
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<tr>
<td>81003</td>
<td>Urinalysis auto w/o scope</td>
</tr>
<tr>
<td>81005</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>81007</td>
<td>Urine screen for bacteria</td>
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<tr>
<td>81025</td>
<td>Urine pregnancy test</td>
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<tr>
<td>82010</td>
<td>Acetone assay</td>
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<tr>
<td>82270</td>
<td>Occult blood feces</td>
</tr>
<tr>
<td>82272</td>
<td>Occult blood feces 1-3 tests</td>
</tr>
<tr>
<td>82570</td>
<td>Assay of urine creatinine</td>
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<tr>
<td>82947</td>
<td>Assay glucose blood quant</td>
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<tr>
<td>82962</td>
<td>Glucose blood test</td>
</tr>
<tr>
<td>83026</td>
<td>Hemoglobin copper sulfate</td>
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<tr>
<td>83036</td>
<td>Glycosylated hemoglobin test</td>
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<tr>
<td>84478</td>
<td>Assay of triglycerides</td>
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<tr>
<td>84520</td>
<td>Assay of urea nitrogen</td>
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<tr>
<td>84703</td>
<td>Chorionic gonadotropin assay</td>
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<td>85013</td>
<td>Spun Microhematocrit</td>
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<tr>
<td>85014</td>
<td>Hemtocrit</td>
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<tr>
<td>85018</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>85610</td>
<td>Prothrombin time</td>
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<td>87449</td>
<td>Ag detect nos eia mult</td>
</tr>
<tr>
<td>87804</td>
<td>Influenza assay w/ optic</td>
</tr>
<tr>
<td>87880</td>
<td>Strep a assay w/ optic</td>
</tr>
</tbody>
</table>
3 Ways to Verify Eligibility with Cigna-HealthSpring CarePlan

1. The Cigna-HealthSpring CarePlan Provider/Member Services Department by calling 1-877-653-0331.

2. TexMedConnect - The State’s eligibility verification system

3. The Cigna-HealthSpring CarePlan secure Provider Portal accessible through the Cigna-HealthSpring CarePlan Website
Interacting with Cigna-HealthSpring CarePlan

Member/Provider Services

Services provided include:

✓ Verify eligibility, benefits and prior authorizations on file
✓ Assist providers to the correct departments
✓ Verify claims receipt or review claims status
✓ Process demographic changes such as PCP on file or Member address changes
✓ Provide assistance with Cigna-HealthSpring’s CarePlan public website & secure Provider Portal

Provider/Member Services Department can be contacted by calling 1-877-653-0331.

Update Your Information

Ensure your office is properly listed in the Cigna-HealthSpring CarePlan Provider Directory and that your claims payments are sent to the correct address by providing timely, advance notification of demographic changes. Email the following types of demographic changes to MedicaidProviderOperations@healthspring.com.
Service Coordination

Cigna-HealthSpring CarePlan offers Service Coordination for Cigna-HealthSpring CarePlan Members in an effort to work collaboratively with Providers & Members to:

• Assess Member health needs
• Create a plan of care
• Organize delivery of healthcare services
• Monitor progress toward Member’s individual health goals.

In addition, Service Coordination assists with long term services & supports such as:

• Adult Foster Care and/or Adult Day Care
• Personal Attendant Services
• Minor Home Modifications
• Home Delivered Meals

Note: To reach a Service Coordinator call 1-877-725-2688.
The Contracting & Provider Relations function includes:

1. Responsibility for maintaining the provider network, ensuring a sufficient number of providers are available in each county to serve the healthcare needs of Members enrolled in Cigna-HealthSpring’s CarePlan Program.

2. Distribute documents to providers and respond to any inquiries related to contracting & credentialing requirements.

3. Serve as the primary liaison with participating providers to resolve any operational challenges between the provider & Cigna-HealthSpring CarePlan.

Note: Provider’s participation in the Cigna-HealthSpring CarePlan network does not automatically include participation in the Medicare Advantage network.
Cigna-HealthSpring’s CarePlan secure Provider Portal is available to participating providers only.

Providers must have a User ID & Password to access the Provider Portal. New Providers must register a User ID & Password online when accessing the Provider Portal.

The Provider Portal allows 24-hour access and is an interactive site where participating Providers are allowed to:

- Verify Member eligibility and PCP on file
- Check claim status
- Request authorizations
- Check authorization status
- Displays Member’s Service Coordinator

Providers can seek assistance with the Provider Portal by calling 1-866-952-7596.
Cigna-HealthSpring CarePlan claims portal, administered by Emdeon.
Providers must have a user ID & password to access the Claims Provider Portal.
Access the Claims portal via HSConnect by selecting the **New Claim tab**.
Slides with portal images are for Cigna-HealthSpring provider portal only.
Registrant must confirm their email in order to view claims under Reporting & Analytics.
The Provider Portal allows 24-hour access and is an interactive site where participating Providers are allowed to:
- Submit claims individually or by batch for CMS 1500 or UB04
- Check claim status individually or by batch
- Correct claims electronically
- Access ERA’s and electronic EOP’s
- Review Reports and Analytics
- Submit electronic appeals
Submit claims within 95 days of date of service. LTSS services should be submitted within 95 days of first date of service. Cigna-HealthSpring CarePlan is required to process clean claims within 30 days of receipt.

3 ways to file a claim with Cigna-HealthSpring CarePlan:

1. Electronically – (Payer ID# 52192) – via 1 of the following 3 Cigna-HealthSpring claims clearinghouses; (1) Change HealthCare, (2) PayerPath, or (3) Availity.

2. Via secure Provider Portal

3. Via Mail paper claims. (See next slide for address)
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Claims Address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute care and LTSS services</strong> (including inpatient acute care services)</td>
<td>Cigna-HealthSpring</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 981709 – CarePlan</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998-1709</td>
</tr>
<tr>
<td><strong>Behavioral health services</strong> (including inpatient behavioral health services)</td>
<td>Cigna-HealthSpring</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 981709 – CarePlan</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79998-1709</td>
</tr>
<tr>
<td><strong>Dental services</strong></td>
<td>DentaQuest-Claims</td>
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<td>Electronic Claims:</td>
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<tr>
<td>Change HealthCare/Availity Payer ID: CX014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12121 North Corporate Parkway</td>
</tr>
<tr>
<td></td>
<td>Mequon, WI 53092</td>
</tr>
<tr>
<td><strong>Vision services</strong></td>
<td>Superior Vision</td>
</tr>
<tr>
<td><a href="http://www.superiorvision.com">www.superiorvision.com</a></td>
<td></td>
</tr>
<tr>
<td>1-800-879-6901</td>
<td></td>
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<tr>
<td></td>
<td>939 Elkridge Landing Road, Suite 200</td>
</tr>
<tr>
<td></td>
<td>Linthicum, MD 21090</td>
</tr>
</tbody>
</table>
3 ways a Provider may appeal a previously processed claim:

1. Fax the request to Cigna-HealthSpring CarePlan at 1-877-809-0783.

2. Mail the request to:
   Cigna-HealthSpring CarePlan
   Appeals and Complaints Department
   PO Box 211088
   Bedford, TX 76095

3. Submit via Cigna-HealthSpring’s CarePlan Provider Portal
   - Requests for reconsideration must be made within sixty (60) days from the date of remittance of the Explanation of Payment (EOP).
   - The appeal will be resolved within thirty (30) calendar days.
Interacting with Cigna-HealthSpring CarePlan

Payment Dispute Form

2 ways a Provider may appeal a previously processed claim:

1. Fax the request to Cigna-HealthSpring CarePlan at 1-877-809-0783.

2. Mail the request to:
   Cigna-HealthSpring CarePlan
   Payment Dispute Unit
   PO Box 211088
   Bedford, TX 76095

Requests for reconsideration must be made within sixty (60) days from the date of remittance of the Explanation of Payment (EOP).

Payment Disputes are requests to review a previously adjudicated claim. This form is not to be used for corrected claims, or claim appeals. A Payment Dispute request from a PAR/NON-PAR Provider must be filed within 120 days (for Medicaid plans) and 60 days (for Medicare-Medicaid Plans (MMP)) from the date of the disposition or the remittance of Explanation of Payment (EOP). Out of State providers must file within 365 days.

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<thead>
<tr>
<th>Member ID</th>
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<th>Claim Number(s):</th>
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<td>4. Denied As A Dx</td>
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<td>5</td>
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<td>5. Incorrect Coding</td>
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<td>6. Applied Income</td>
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<td>7</td>
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<td>7. RUG Level Chg</td>
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<td>8</td>
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<td></td>
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<td>8. Other Reasons</td>
</tr>
</tbody>
</table>

Comments:

1. For claims that are partially paid or denied, please re-submit this form with supporting documents:
   a. Copy of the Remittance Advice
   b. Copy of the Original Invoice (if applicable)
   c. Other requesting documents

2. To send completed Claims Adjustment Form, please fax to 1-877-809-0783 e-mail to Claims_MMP_Medicaid@HealthSpring.com or mail to:
   Cigna HealthSpring Payment Dispute Unit
   P.O. Box 211088
   Bedford, TX 76095

For any questions, please contact Provider Services at: 1-877-653-0331.
Payment Disputes are requests when a provider is disputing and/or requesting a claim to be reviewed for denial or partial payment. Examples of the denial reasons are listed below. For a full list contact Provider Services at 1-877-653-0331.

- For “timely filing”, but provider has proof of timely
- For “no auth on file”, but provider has auth listed
- For “benefit not covered”, but per TMHP it is payable
- For “no coverage”, but member was active during the DOS
- Provider not being paid at correct reimbursement rate, we paid incorrectly
- For “no active provider contract” and provider has an active contract listed
- For insufficient units, per auth on file there’s units available
- For “no member match” but the member was active for DOS, and DOB, ID and name all match the original submission
Interacting with Cigna-HealthSpring CarePlan

Payment Disputes/Appeal vs. Corrected Claims

- **Payment Disputes/Appeal** – A payment disputes/appealed claim is a claim that has been previously adjudicated as a Clean Claim and the provider is appealing the disposition through written notification to the Managed Care Organization. e.g., an appeal based on a discrepancy with the amount paid to a provider; a written notification appealing the disposition on a previously adjudicated clean claim.

- **Corrected claim** – A corrected claim is a claim that has already been adjudicated, whether paid or denied. A provider would submit a corrected claim if the original claim adjudicated needs to be changed. e.g., provider billed with an incorrect date of service/incorrect number of units.
Submit Corrected Claims Electronically

Claims

Claims List - Claims List allows you to view, edit, submit and manage claims. Before using Claim List for the first time, you must have completed and saved the claim. Any claim can be edited and saved as a new claim, which helps to avoid re-keying the same information for multiple claims per patient. Only available for CMS 1500 claims format.

• From the Claims tab, select Claims List
• Search for your previously keyed claim in the Search Text field
• Once you have selected the claim that you want to correct, select Edit, the previously keyed claim will open and you are able to change the information within the claim template.
Once corrections are made, scroll to the bottom of the page, and enter the number “7” at the Resubmission Code field to indicate it’s a corrected claim.

Enter original claim number from which you are correcting at the Resubmission Reference Number field – the claim number must be exact.

Do not remove existing text from the “Remarks” field.

Click Save as New Claim.

Your claim is now updated with your corrections.

Return to the Claims List to retrieve the corrected claim from the Claims List.

Once you select the new claim, click Submit Selected.
Submit Electronic Appeal

- Retrieve the claim you want to appeal from the “Claims List”
- Once the claim is selected, choose “Edit” (the original claim will open)
- At Step 5 - select the “Comment” box, which will allow you to write the reason for appeal.
- At Step 9 - Other information → Workers Condition Code, select the option 1st Level appeal (request with insurance carrier) will appear in the drop-down box.
- In the “Remarks” field, *BGW3 will appear, indicating it’s an appealed request.
- Save claim as new and return back to the “Claims List”.
- Retrieve claim from “Claims List” and “Submit”.

Note: Only available for CMS 1500 claims format.
Skilled Nursing Facility Providers should bill claims as traditionally billed with TMHP.

- **Medicare benefit** - Skilled services are billed with appropriate RUG level, per Medicare guidelines for days 1-20.
- **Medicaid benefit** - Medicaid will cover the co-insurance for Medicare for days 21-100. These services to be billed with Revenue Code 0101.
- **Medicaid benefit** – Day 101, and thereafter bill Revenue Code 0100.

**Note:** The 3-day inpatient rule does not apply for MMP members wanting to enter into a Skilled Nursing Facility.
Nursing Facility Program Overview, cont.

Claims for MMP Providers

- The MCO will pay the State’s Medicare co-insurance obligation for days 21 to 100 of a Dual Eligible Member’s Medicare-covered stay in a Nursing Facility.

- The Provider may submit claims for Medicare Coinsurance through a portal operated by the MCO or its designee, or an HHSC-designated portal.

- The MCO may deny a claim for Medicare Coinsurance for failure to file timely if the Provider does not submit the claim to the MCO or its designee, or the HHSC-designated portal, within 365 days of the date of service.

- The MCO will Adjudicate Clean Claims for Medicare Coinsurance no later than 10 days after the claim is received by the MCO or its designee.

- If the Provider files a claim for Medicare Coinsurance with a third-party insurance resource, the wrong health plan, or with the HHSC’s administrative services contractor, and produces documentation verifying that the initial filing met the timeliness standard, the MCO will process the claim without denying the resubmission for failure to timely file.
Interacting with Cigna-HealthSpring CarePlan

Claims

Electronic Funds Transfer (EFT)

Cigna-HealthSpring contracts with Change HealthCare to deliver electronic funds transfer services. If you are an existing EFT customer with Change HealthCare and wish to add Cigna-HealthSpring to your service, please call 1-866-506-2830, and select Option 1 to speak with a Change HealthCare Enrollment Representative, mention Payer ID 52192.

- There is no cost for providers to enroll in EFT.

- If you would like to learn more or sign up for EFT, please visit Change HealthCare’s ePayment Web site at www.emdeonepayment.com.
Interacting with Cigna-HealthSpring CarePlan

Claims

Electronic Remittance Advice (ERA)

Providers who are able to automatically post 835 remittance data will save posting time and eliminate keying errors by taking advantage of 835 ERA file service.

ERA Enrollment Process

- Download Change HealthCare Provider ERA Enrollment Form at the following location: [http://www.emdeon.com/resourcepdfs/ERAPSF.pdf](http://www.emdeon.com/resourcepdfs/ERAPSF.pdf)
- Complete and submit ERA Enrollment Form via Email or Fax to Change HealthCare ERA Group:
  - Email: batchenrollment@emdeon.com
  - Fax: 1-615-885-3713
- Any questions related to ERA Enrollment or the ERA process in general, please call Change HealthCare ePayment Solutions at 1-866-506-2830 for assistance.
- NOTE: ERA enrollment for all Cigna-HealthSpring health plans must be enrolled under Cigna-HealthSpring CarePlan Payer ID “52192”.

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Interacting with Cigna-HealthSpring CarePlan

Sample of (Explanation of Payment) EOP

Explanation of Payment will display:

- Provider’s information
- Members processed on that payment
- Payment information
- Remark Code Explanation

Providers should not collect payment from or bill Cigna-HealthSpring CarePlan members for covered services.
Cigna-HealthSpring CarePlan Key Partners

Vison and Dental

- **Dental Services – DentaQuest** – *DentaQuest* provides dental services to all Cigna-HealthSpring CarePlan Members. Dental providers must contract with DentaQuest to provide dental services.

- **Vision Services – Superior Vision** – *Superior Vision* provides vision services to all Cigna-HealthSpring CarePlan Members. Vision providers must contract with Superior Vision to provide vision services.
A coverage determination is the decision made by the plan about a member's Part D benefits, including whether a drug is covered, or whether to make an exception to a plan rule when the member or doctor requests it. The Part D plan sponsor must accept both oral and written requests for coverage determinations. That information may be found at the following website: http://www.cigna.com/medicare/healthcare-professionals/tx-mmp

Cigna-HealthSpring CarePlan Providers Pharmacy Authorization

- Contact: 1-888-671-7379
- Fax number for Pharmacy Prior Authorizations: 1-888-766-6341

A Coverage Determination Form may be found on our website under the Pharmacy tab: http://www.cigna.com/medicare/healthcare-professionals/tx-mmp

Federal & Texas laws require that a 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This rule applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits. Pharmacies will be paid in full for 72-hour emergency prescription claims.
Legal Obligation: Americans with Disabilities Act (ADA) Requirements

- Is your current practice location accessible, clearly marked and visible from the street and marked throughout your facility?
- Is your current practice location easily accessible via public transportation?
- Is your office handicap accessible?
  > Designated handicap parking?
  > Wheelchair ramps?
  > Equipped exam rooms?
  > Equipped rest rooms with rails?
  > Auto-Open external doors?
- Do you have procedures in place for handling visually and/or hearing impaired patients?
- Can your waiting room accommodate patients in wheelchairs or motorized scooters?
- If you offer radiology and/or other diagnostic services, are they accessible to patients?

If the answer is “NO” to any of these, we will coordinate with you to have our Coalition of Limited English Speaking Elderly (CLESE) vendor suggest ways in which you can make these accommodations. Contact: 1-312-461-0812.
Fraud, Waste and abuse

Definitions

**Fraud:** Intentional deception or misrepresentation to obtain money or products of a health care benefit program by false or fraudulent pretenses/representation.

**Waste:** The over-utilization of services that result in unnecessary costs.

**Abuse:** Obtaining payment for items or services when there is no legal entitlement to that payment, but without knowing and/or intentional misrepresentation of facts to obtain payments, resulting in unnecessary costs to the Medicare program or improper payment for services that fail to meet professionally recognized standards of care or that are medically necessary.

What are the differences between Fraud, Waste and Abuse?

One of the primary differences is intent and knowledge. Fraud requires the person to have intent to obtain payment and the knowledge that his or her actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge as Fraud.
Fraud, Waste and abuse

Examples of Fraud, Waste and Abuse

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law.

For example, tell us if you think someone is:

• Getting paid for services that weren’t given or necessary.
• Not telling the truth about a medical condition to get medical treatment.
• Letting someone else use his/her Medicaid ID.
• Using someone else’s Medicaid ID.
• Not telling the truth about the amount of money or resources he/she has in order to receive benefits.
Fraud, Waste and abuse

Lines of Communication

Cigna-HealthSpring's Benefit Integrity Unit at:
> 1-800-230-6138, Monday through Friday, 8:00 AM to 6:00 PM CST

Office of Inspector General
- Fraud Hotline (OIG) at 1-800-436-6184
- Visit http://oig.hhsc.state.tx.us/. Under the box labeled “I WANT TO” click “Report Waste, Abuse and Fraud” to complete the online form.

You may also send correspondence to the following addresses:

To report Providers, use this address:
Office of Inspector General
Medicaid Provider Integrity/Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200

To report Members, use this address:
Office of Inspector General
Medicaid Provider Integrity/Mail Code 1362
P.O. Box 85200
Austin, TX 78708-5200
Culture and Cultural Competency

**Culture:** refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people.

**Cultural competency:** is the capability of effectively interacting with people from different cultures by understanding, respect, appreciation for cultural differences.

**Culture will often define:**
- who provides treatment
- what is considered a health problem
- what type of treatment
- where care is sought
- how symptoms are expressed
- how rights and protections are understood

> For a complete presentation, and to take the *mandatory* online training course, visit our website [http://www.cigna.com/medicare/healthcare-professionals/tx-mmp](http://www.cigna.com/medicare/healthcare-professionals/tx-mmp)
The Affordable Care Act Section 2602 Requires the Federal Coordinated Health Care Office to integrate Medicare and Medicaid benefits in order to improve the quality of, and access to, care for dual eligible individuals in the counties in which the MMP will be implemented.

Improving the coordination between the federal and state governments for individuals eligible for both Medicare and Medicaid benefits.

Establishing one set of benefits for the enrollee that encompasses both Medicare & Medicaid benefits that is administered by one MCO through the Medicare Medicaid Program (MMP).

All providers must receive training on the MOC initially and annually thereafter. Please go to the below link to familiarize yourself with the SNP Model of Care.

In order to receive credit for completing the Model of Care training course you must complete a short set of questions and attest that you have completed the training.

http://www.cigna.com/medicare/healthcare-professionals/tx-mmp
## SPECIAL NEEDS PLAN MODEL OF CARE (MOC): 4 domains, 14 elements*

### MOC 1: Description of the SNP Population
- **A. Sub-Population**: Define how the most vulnerable beneficiaries will be identified

### MOC 2: Care Coordination
- **A. Cutline roles and responsibilities of staff responsible for the MMP Population**
- **B. Comprehensive Health Risk Assessment Process**

### MOC 3: SNP Provider Network:
- **A. Specialized Expertise**
- **B. Use of Clinical Practice Guidelines & Care Transitions Protocols**
- **C. MOC Training for the Provider Network**
- **D. Specialized and credentialed providers with expertise to manage the needs of the MMP population and to meet CMS network adequacy requirements**

### MOC 4: MOC Quality Measurement & Performance Improvement
- **A. MOC Quality Performance Improvement Plan**
- **B. Measureable Goals & Health Outcomes for the MOC**
- **C. Measuring Patient Experience of Care (SNP Customer Satisfaction)**
- **D. Ongoing Performance Improvement Evaluation of the MOC**
- **E. Dissemination of SNP Quality Performance related to the MOC**

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* Determined and required by the Centers for Medicare and Medicaid Services

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The Cigna-HealthSpring CarePlan website is available at:

http://www.cigna.com/medicare/healthcare-professionals/tx-mmp

The website includes much of the information included in today’s presentation and allows providers to download numerous additional, more informative resources as well, such as:

- Provider Manual
- Quick Reference Guide
- Provider Directory
- LTSS Billing Guidelines
  - Cultural Competency Presentation *required training
  - Special Needs Plan MOC Presentation *required training
- Upcoming Trainings
- Provider Updates
<table>
<thead>
<tr>
<th>INTERNAL CONTACTS</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Behavioral Health Crisis Hotline- Hidalgo</td>
<td>1-888-843-1315</td>
</tr>
<tr>
<td>Behavioral Health Substance Abuse Services</td>
<td>1-877-725-2539</td>
</tr>
<tr>
<td>Claims Status Request</td>
<td>1-877-653-0331</td>
</tr>
<tr>
<td>Compliance Hotline</td>
<td>1-877-653-0331</td>
</tr>
<tr>
<td>Cigna-HealthSpring CarePlan Pharmacy</td>
<td>1-877-653-0331</td>
</tr>
<tr>
<td>Cigna-HealthSpring Automated Eligibility Verification Line</td>
<td>1-866-467-3126</td>
</tr>
<tr>
<td>Provider/Member Services Department</td>
<td>1-877-653-0331</td>
</tr>
<tr>
<td>Utilization Management – Service Coordination</td>
<td>1-877-725-2688</td>
</tr>
<tr>
<td>Utilization Management – Concurrent Review &amp; Skilled Nursing Facility</td>
<td>1-877-725-2688</td>
</tr>
<tr>
<td>Utilization Management – Home Health</td>
<td>1-877-725-2688</td>
</tr>
<tr>
<td>Utilization Management – Inpatient Intake</td>
<td>1-877-725-2688</td>
</tr>
<tr>
<td>Utilization Management – Prior Authorization</td>
<td>1-877-725-2688</td>
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## IMPORTANT PHONE NUMBERS

<table>
<thead>
<tr>
<th>EXTERNAL CONTACTS</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>24- Hour Nurse Line - Health Information Line (HIL)</td>
<td>1-855-418-4552</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS), Eligibility Verification</td>
<td>1-800-925-9126</td>
</tr>
<tr>
<td>Coalition of Limited English Speaking Elderly (CLESE)</td>
<td>1-312-461-0812</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>1-800-846-7470</td>
</tr>
<tr>
<td>Dental (DentaQuest) – Provider Services</td>
<td>1-888-308-9345</td>
</tr>
<tr>
<td>Dental (DentaQuest) – Member Services</td>
<td>1-855-418-1628</td>
</tr>
<tr>
<td>Change HealthCare (formerly known as Emdeon)</td>
<td>1-800-845-6592</td>
</tr>
<tr>
<td>Laboratory Services (Quest Diagnostics)</td>
<td>1-800-522-9235</td>
</tr>
<tr>
<td>Laboratory Services (CPL)</td>
<td>1-800-595-1275</td>
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<tr>
<td>Laboratory Services (LabCorp)</td>
<td>1-888-522-2677</td>
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<tr>
<td>Laboratory Services (ProPath)</td>
<td>1-866-776-7284</td>
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<tr>
<td><strong>MAXIMUS (Medicaid Managed Care Helpline)</strong></td>
<td><strong>1-800-964-2777</strong></td>
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<tr>
<td>Medicaid Managed Care Helpline</td>
<td>1-866-566-8989</td>
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<tr>
<td>Medicaid Managed Care Helpline TDD</td>
<td>1-866-222-4306</td>
</tr>
<tr>
<td>Medical Transportation Program (MTP) – Hidalgo SDA</td>
<td>1-877-633-8747</td>
</tr>
<tr>
<td>Texas Department of Family &amp; Protective Services (TDFPS)</td>
<td>1-800-252-5400</td>
</tr>
<tr>
<td>Vision (Superior Vision)</td>
<td>1-800-879-6901</td>
</tr>
</tbody>
</table>
Thank you for reviewing the MMP Provider In-Service Training.

If you are ready to take the quiz and acknowledge completion click CONTINUE.

If you would like to review the training again prior to taking the quiz, then review the presentation again from the beginning slide.