Hidalgo Service Area:
Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, and Zapata Counties

Tarrant Service Area:
Denton, Hood, Johnson, Parker, Tarrant, and Wise Counties

MRSA-Northeast Service Area:

TX MMP Service Area:
Hidalgo County

Publication date: July 2017
Dear Valued Provider and Staff:

I would like to extend a warm welcome and thank you for participating with Cigna-HealthSpring Texas’ Network of Participating Providers. We value our relationship with all of our providers and are committed to working with you to meet the needs of your Cigna-HealthSpring patients.

Cigna-HealthSpring has provided managed care services to Medicare and Dually-eligible members since 1996. We are excited to extend our passion for offering quality health care delivery to Texas STAR+PLUS and MMP members.

We look forward to working with you to serve the needs of Texas STAR+PLUS and MMP members in order that they may live life well.

Sincerely,

Jay Hurt
Senior Vice President
President – Texas Division
Cigna-HealthSpring
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## Important Phone Numbers

For quick reference information about Cigna-HealthSpring and the STAR+PLUS program, providers can visit our website at [http://starplus.cignahealthspring.com](http://starplus.cignahealthspring.com) or our provider portal at [https://starplus.hsconnectonline.com](https://starplus.hsconnectonline.com). PLEASE NOTE: Users should not enter "www" prior to entering the web address for the provider portal. Also, providers can call the following resources for more information.

<table>
<thead>
<tr>
<th><strong>Cigna-HealthSpring Contacts</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services Department</td>
<td>1-877-653-0331</td>
</tr>
<tr>
<td>Member Service Department</td>
<td>1-877-653-0327</td>
</tr>
<tr>
<td>Behavioral Health Substance Abuse Services</td>
<td>1-877-725-2539</td>
</tr>
<tr>
<td>Behavioral Health Crisis Hotline</td>
<td>1-800-959-4941</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 Automated Eligibility Verification Line</td>
<td>1-866-467-3126</td>
</tr>
<tr>
<td>Cigna-HealthSpring Pharmacy</td>
<td>1-888-671-7379</td>
</tr>
<tr>
<td>Service Coordination</td>
<td>1-877-725-2688</td>
</tr>
<tr>
<td>Utilization Management - Concurrent Review</td>
<td>1-877-725-2688</td>
</tr>
<tr>
<td>Utilization Management – Home Health / Long-Term Services and Supports</td>
<td>1-877-725-2688</td>
</tr>
<tr>
<td>Utilization Management - Inpatient Intake Prior Authorization</td>
<td>1-877-725-2688</td>
</tr>
<tr>
<td>Utilization Management – Outpatient Prior Authorization</td>
<td>1-877-725-2688</td>
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<tr>
<th><strong>External Contacts</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td>TMHP Automated Inquiry System (AIS), Eligibility Verification</td>
<td>1-800-925-9126</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>1-800-846-7470</td>
</tr>
<tr>
<td>Dental</td>
<td>DentaQuest:</td>
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<td></td>
<td>Providers:</td>
</tr>
<tr>
<td></td>
<td>1-888-308-9345</td>
</tr>
<tr>
<td></td>
<td>Members:</td>
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<tr>
<td></td>
<td>1-855-418-1628</td>
</tr>
<tr>
<td>Change Health Care (EDI) (formerly Emdeon)</td>
<td>1-800-845-6592</td>
</tr>
<tr>
<td>MAXIMUS (Medicaid Managed Care Helpline)</td>
<td>1-800-964-2777</td>
</tr>
<tr>
<td>Medicaid Managed Care Helpline</td>
<td>1-866-566-8989</td>
</tr>
<tr>
<td>Medicaid Managed Care Helpline TDD</td>
<td>1-866-222-4306</td>
</tr>
<tr>
<td>Texas Department Of Family And Protective Services (TDFPS)</td>
<td>1-800-252-5400</td>
</tr>
<tr>
<td>Vision</td>
<td>1-800-879-6901</td>
</tr>
</tbody>
</table>
Introduction

Welcome to Cigna-HealthSpring’s STAR+PLUS program. Cigna-HealthSpring was selected by the Texas Health and Human Services Commission (HHSC) to be one of the STAR+PLUS Managed Care Organization MCOs serving the Tarrant Service Area, Hidalgo Service Area, and the MRSA Northeast Service Area.

We look forward to partnering with you to meet the needs of your patients, our members. This provider manual is a reference for providers concerning Cigna-HealthSpring's STAR+PLUS operating requirements. Providers should use this provider manual in conjunction with the Cigna-HealthSpring participating provider agreement to understand important participation requirements such as:

- Services that are covered under STAR+PLUS
- How to determine member eligibility
- How to access health care services within Cigna-HealthSpring's network
- How to file claims with Cigna-HealthSpring
- Provider roles and responsibilities
- How and when to obtain authorization for Add-on services
- Cigna-HealthSpring's Quality Management Program
- Member roles and responsibilities

Cigna-HealthSpring cultivates strong business relationships with members, providers, HHSC and local community organizations, with the goal of delivering excellent service to each. Our promise to providers is to bring value to their businesses by offering expeditious claims processing and simple administrative requirements. For members, we strive to:

- Ensure members receive the appropriate level of care, in the least restrictive setting, and consistent with their personal health and safety
- Improve access to health care
- Improve the quality of health care
- Assure satisfaction

Cigna-HealthSpring conducts its business affairs in accordance with federal and state laws. Cigna-HealthSpring takes the privacy and confidentiality of members’ health information seriously. Cigna-HealthSpring complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas regulatory requirements.

This provider manual is current as of its publication date. Cigna-HealthSpring reserves the right to make updates as necessary and will make updates available to providers promptly.
STAR+PLUS Program Overview
STAR+PLUS is a Texas Medicaid managed care program designed to coordinate and provide preventive, primary, acute care, Long-Term Services and Supports (LTSS) and Nursing Facility services through a managed care delivery system for persons of all ages with disabilities as well as for elderly persons age sixty-five (65) and over who qualify for Medicaid through Supplemental Security Income (SSI) or Medical Assistance Only (MAO). The STAR+PLUS Program assists Medicaid Members who have disabilities, special health care needs or chronic and complex conditions and require more extensive care than acute care services alone. For this reason, service coordination is a key feature of STAR+PLUS. Service coordination allows Medicaid Members, their family members, and providers to work together to coordinate acute care services, LTSS, and other community services. In the STAR+PLUS Program, members choose an MCO from those available in their Service Area and receive Medicaid services and service coordination through that MCO. Eligibility and Enrollment for STAR+PLUS is discussed in greater detail in the STAR+PLUS Eligibility & Enrollment section of this provider manual.

Objectives of the STAR+PLUS Program
Through contracts with MCOs, HHSC’s goal is to integrate acute care, LTSS and Nursing Facility care, including services provided through continuity of care and timely access to quality care through an adequate provider network that includes behavioral health services and disease management services.

The objective of the STAR+PLUS Program is to:

- Prevent or delay the institutionalization of members through effective use of Long-Term Services and Supports and provide holistic support to members who are in Nursing Facilities
- Assign Medicaid-only members to a medical home
- Conduct utilization management to ensure appropriate access to and utilization of Medicaid services
- Assess member’s health risks and functional needs
- Notify the member’s medical home and other providers about the member’s service utilization and associated costs
- Reduce inappropriate emergency room utilization
- Provide competent service coordination which includes assessing, service planning, monitoring and coordinating care for members with complex, chronic, or high cost health care or social support needs, including services members need to remain in or return to the community
- Provide comprehensive, community-based education to members regarding STAR+PLUS, while ensuring access to services for members with physical or mental disabilities and members with limited English proficiency

Role of the Nursing Facility Provider
Nursing Facility Providers provide institutional care to Medicaid recipients whose medical condition regularly requires the attention and skills of licensed nurses. A Cigna-HealthSpring Nursing Facility must provide for the Unit Rate services of total medical, social and
psychological needs of each Member, including room and board, social services, over-the-counter drugs, medical supplies and equipment, and personal needs items. Nursing Facility Add-on Services are the services that are provided in the Facility setting by the Provider or another network provider, but are not included in the Nursing Facility Unit Rate. Nursing Facility add-on services include but are not limited to: emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, augmentative communication devices, and radiology services. The expectation of the Nursing Facility is to improve the quality of care, and to better coordinate services and health care needs for members.

**Role of the Primary Care Provider (PCP)**

Except for Dually-eligible members, Cigna-HealthSpring members must select an in-network Primary Care Provider (PCP) to oversee their care. PCPs are normally selected by the member during the enrollment process. If a member does not select a PCP during the enrollment process, one will be auto-assigned to him/her, based on PCP proximity by HHSC’s enrollment broker, MAXIMUS. Members may change PCPs at any time by calling the Cigna-HealthSpring Member Service Department at 1-877-653-0327.

A PCP may specialize in the following specialties:

- General practice /
- Family practice
- Internal medicine
- Obstetrics/Gynecology (OB/GYN)
- Pediatrics

When practicing under the supervision of a participating Cigna-HealthSpring physician, advanced practice nurses (APNs) may serve as PCPs. Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Community Clinics may serve as PCPs. Specialty Care Providers serve as PCPs under specific circumstances. The circumstances under which this may occur are discussed in the Member Service section of this provider manual.

The PCP serves as the "medical home” or the entry point for access to health care services. The PCP provides or arranges for all medically necessary primary care services and refers member for specialty care when necessary. Cigna-HealthSpring PCPs are responsible for the following:

- Verifying member eligibility prior to rendering services
- If indicated, obtaining authorizations prior to rendering services
- Managing the health care needs of all assigned members
- Providing continuity of care for members
- Ensuring that each member receives medically necessary treatment based on the member’s condition
- Providing behavioral health services within his or her scope of practice
- Complying with Cigna-HealthSpring’s prior authorization procedures
- Using appropriate ancillary services
- Referring members to participating Cigna-HealthSpring providers
- Referring members for a second opinion, if requested
Complying with Cigna-HealthSpring's emergency care procedures
Notifying Cigna-HealthSpring of any barriers to a member's care
Adhering to Cigna-HealthSpring’s medical record standards as outlined in this provider manual
Complying with Cigna-HealthSpring’s Quality Management and Utilization Management programs
Complying with preventive screening and clinical guidelines
Being culturally sensitive to members
Complying with Cigna-HealthSpring's credentialing and re-credentialing requirements
Complying with Cigna-HealthSpring's access and availability standards as outlined in this provider manual
Using a National Provider Identification (NPI) number
Billing services in accordance with the billing procedures outlined in the STAR+PLUS provider manual
When billing for services provided, using specific coding to capture the acuity and complexity of a member’s condition and ensuring that submitted codes are supported by the medical record
Notifying Cigna-HealthSpring and HHSC’s administrative services contractor of any changes to the provider’s address, telephone number, group affiliation, etc.

Role of the Specialty Care Provider
Specialty Care Providers play an essential role in caring for members. A Cigna-HealthSpring Specialty Care Provider is responsible for providing health care services to members who require care beyond the capabilities of a PCP. Specialty Care Providers must render covered health services within the scope of their practice and license, in the same manner, according to the same standards, and within the same time availability as offered to their other patients. It is the responsibility of the Specialty Care Provider to communicate their findings and recommendations with each member's PCP in order to promote coordination and continuity of care.

Cigna-HealthSpring Specialty providers are responsible for the following:

- Verifying member eligibility prior to rendering services
- If required, obtaining authorizations prior to rendering services
- Providing specialty health care services to members as needed
- Collaborating with the member’s PCP to ensure continuity of care and appropriate treatment
- Providing consultative and follow-up reports to the PCP in a timely manner
- Referring members to participating Cigna-HealthSpring providers
- Complying with Cigna-HealthSpring’s prior authorization procedures
- Complying with Cigna-HealthSpring's access and availability standards as outlined in this provider manual
- Complying with Cigna-HealthSpring’s Quality Management and Utilization Management programs
• Adhering to Cigna-HealthSpring’s medical record standards as outlined in this provider manual
• Using a National Provider Identification (NPI) number
• Billing services to Cigna-HealthSpring in accordance with the billing procedures outlined in this provider manual
• When billing for services provided, using specific coding to capture the acuity and complexity of a member’s condition and ensuring that submitted codes are supported by the medical record

**Missed appointments by Membership**
Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Cigna-HealthSpring requests providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact may be by telephone, allowing the provider to educate the member about the importance of keeping appointments. It’s also a good time for the provider to encourage the member to reschedule the appointment.

Cigna-HealthSpring members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, providers can call Provider Services at 1-877-653-0331 or Cigna-HealthSpring’s Behavioral Health Team at 1-877-725-2539. Our staff contacts the member and offers more extensive education through our case management team. It is imperative that our members recognize the importance of maintaining preventive health visits and following their PCP’s recommended plan of care.

**Role of Service Coordinator**
Cigna-HealthSpring’s Health Services Department manages the medical and behavioral health services of our members through a comprehensive, preventative, and therapeutic delivery system. Our goal is to ensure for every member quality services, which are timely and clinically appropriate yet cost-effective and in the least restrictive environment. To reduce avoidable admissions into acute and long term care, we proactively manage chronic conditions. We strive to improve each member’s quality of life by helping them access community and governmental resources to meet any unaddressed psychological or social needs.

Service Coordination being under the supervision of health care professionals at both the Director and Vice President levels is key to Cigna-HealthSpring’s success.

The Service Coordinators:
• Perform a face-to-face visit to each NF resident at least quarterly to assess each member’s needs
• Coordinate services to ensure appropriate utilization of health care resources
• Assist members in locating community resources to meet non-health care needs
• Perform ongoing evaluations of members’ needs
• Engage with health care providers to ensure a holistic approach to treatment
- Collaborate with internal departments, such as Quality Improvement, Appeals and Grievances, Provider Relations and Member Service, Utilization Management, and the Office of the Medical Director
- Service coordination allows Medicaid Members, their family members, and providers to work together to coordinate acute care services, LTSS, and other community services. The Service Coordinator will partner with nursing facility coordinators and other nursing facility staff.

These duties are to improve members’ access to services and health outcomes, while ensuring proper allocation of benefits.

Within 30 days of enrollment, Service Coordination teams contact all members telephonically to complete an assessment and triage enrollees. All members who reside in a Nursing Home are assigned a Level 1 Service Coordinator and are contacted according to the following criteria:

<table>
<thead>
<tr>
<th>Member Level</th>
<th>Determination of Assignment</th>
<th>Service Coordinator Requirements and Requisite Number and Types of Visits</th>
</tr>
</thead>
</table>
| Level 1      | ● All Nursing Home residents.  
               ● All SPW members  
               ● Non SPW members who have had 3 or more claims for unique hospitalizations (non BH) in the last 9 months  
               ● Non SPW members who have had 3 or more authorizations for unique hospitalizations (non BH) in the last 6 months  
               ● Pediatric members with PDN or PCS services  
               ● A member will move to a lower level if they have not been hospitalized for the last 6 months or if they have lost their SPW eligibility. Pediatric members will move to a lower level if they no longer receive PDN or PCS services. | ● Assigned to a single identified RN  
Seen a minimum of four times per year face-to-face. |

The NF staff will coordinate with the MCO service coordinator regarding any care or treatment needs; in order to ensure that member needs are met and that continuity of care is optimized.

**Role of the Pharmacy Provider**
Cigna-HealthSpring members have the right to have their medications filled at any network pharmacy that they choose. For a list of network pharmacies in your area, please call Cigna-HealthSpring Provider Services department at 1-877-653-0331. Cigna-HealthSpring Pharmacy providers are responsible to:

- Adhere to the State Formulary
- Coordinate with the prescribing physician
- Ensure members receive all medications for which they are eligible
- Coordinate benefits when member also receives Medicare Part D services or other insurance benefits
- Adhere to the Preferred Drug List (PDL)

**Network Limitations**
Cigna-HealthSpring has no network limitations on referrals from PCPs to in-network Specialty Care Providers or Ancillary providers. Except for Dually-eligible members who do not select a PCP, members must select a PCP or be referred to a Specialty Care Provider within the Cigna-
HealthSpring network. Use of a specific referral form is not necessary, as long as the PCP is directing care. Additionally, female members may seek obstetrical and gynecological services from any participating OB/GYN without a referral from their PCP. A member also may choose an OB/GYN as her PCP from the list of participating Cigna-HealthSpring providers.

Cigna-HealthSpring members may select and have access to, without a Primary Care Provider referral, a Network Ophthalmologist or Therapeutic Optometrist to provide eye health care services other than surgery.

Focus Studies and Utilization Management Reporting Requirements
Cigna-HealthSpring’s quality team is involved in conducting clinical and service utilization studies that may require a medical record review. This gives us an opportunity to conduct gap analysis of the date and to look for and share opportunities for improvement in our network providers.

Covered Services

Unit Rate
Nursing Facility Unit Rate means the types of services included in the DADS daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable nursing facility staffing rate enhancements and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility Add-on Services. For additional information regarding Unit Rate services, contact Cigna-HealthSpring Provider Services department at 1-877-653-0331. For modifier requirements please reference: https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/sph-appendix-xvi-long-term-services-supports-codes-modifiers. For additional authorization requirements reference the Medical Management/Utilization Management section of this manual.

Unit Rate Services can be authorized by filling out a Form 3618 and/or Form 3619 and sent to TMHP.

Add-on Services
Nursing Facility Add-on Services means the types of services that are provided in the Facility setting by the Provider or another network provider, but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services; physician-ordered rehabilitative services; customized power wheel chairs; and augmentative communication devices. For additional information regarding add-on services, contact Cigna-HealthSpring Provider Services department at 1-877-653-0331.

Add-on Services will have to be requested directly with Cigna-HealthSpring for authorization approval.

Nursing Facility MCO Add-on Services
**Ventilator Care add-on service:** To qualify for supplemental reimbursement, a Nursing Facility resident must require artificial ventilation for at least six consecutive hours daily and the use must be prescribed by a licensed physician.

**Tracheostomy Care add-on service:** To qualify for supplemental reimbursement, a Nursing Facility resident must be less than 22 years of age; require daily cleansing, dressing, and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.

**PT, ST, OT add-on services:** Rehabilitative services are physical therapy, occupational therapy, and speech therapy services (not covered under the NF Unit Rate) for Medicaid nursing facility residents who are not eligible for Medicare or other insurance. The cost of therapy services for residents with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by illness. Rehabilitative services must be provided with the expectation that the resident's functioning will improve measurably in 30 days. Prior Authorization is required. Unless the provider of the service is billing through the NF, the provider must be a Cigna-HealthSpring network provider.

The provider must ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the resident's clinical record.

**Customized Power Wheelchair (CPWC):** Prior Authorization is required. Unless the provider of the service is billing through the NF, the provider must be a Cigna-HealthSpring network provider.

To be eligible for a CPWC, a resident must be:
- Medicaid eligible
- Age 21 years or older
- Residing in a licensed and certified Nursing Facility that has a Medicaid contract with the Department of Aging and Disability Services (DADS)
- Eligible for and receiving Medicaid services in an Nursing Facility
- Unable to ambulate independently more than 10 feet
- Unable to use a manual wheelchair
- Able to safely operate a power wheelchair
- Able to use the requested equipment safely in the Nursing Facility
- Unable to be positioned in a standard power wheelchair
- Undergoing a mobility status that would be compromised without the requested CPWC
- Certified by a signed statement from a physician that the CPWC is medically necessary
- The request must meet medical necessity criteria

**Augmentative Communication Device (ACD)**
An ACD is a speech-generating device system available to nursing facility residents. A physician and a licensed speech therapist must determine if the ACD is medically necessary. Prior Authorization is required.
Note: For Nursing Facility add-on therapy services, Cigna-HealthSpring will accept claims received (1) from the Nursing Facility on behalf of employed or contracted therapists; and (2) directly from contracted therapists who are contracted with the MCO. All other Nursing Facility add-on providers must contract directly with and directly bill the MCO.

Nursing facility add-on providers (except Nursing Facility add-on therapy services providers) must refer to the STAR+PLUS provider manual for information including credentialing and re-credentialing.

**Behavioral Health Covered Services**

Behavioral Health Services means covered services for the treatment of mental, emotional, or chemical dependency disorders. Cigna-HealthSpring provides a behavioral health benefit package to STAR+PLUS members that include all medically-necessary services covered under the traditional fee-for-service Medicaid programs. The following list provides an overview of these benefits. Providers can refer to the current Texas Medicaid Provider Procedures Manual.

**Behavioral Health Services, including:**
- Inpatient mental health services for adults and children
- Outpatient mental health services for adults and children
- Partial Hospitalization (PHP) and Intensive Outpatient Services (IOP)
- Psychiatry services
- Counseling services for adults (21 years of age and over)
- Electroconvulsive therapy (ECT)
- Psychological Testing
- Targeted Case Management Services
- Mental Health Rehabilitation Services
- Cognitive Rehabilitation Therapy

**Substance use disorder treatment services, including:**
- Detoxification services
- Medication assisted therapy (MAT)

**Residential services, including**
- Detoxification services
- Substance use disorder treatment (including room and board)

Cigna-HealthSpring provides an integrated health delivery model that utilizes all necessary resources and providers to promptly identify precipitating factors that influence members’ overall health. Cigna-HealthSpring ensures that behavioral health services are available at the appropriate time and in the least restrictive setting possible, so members can safely access care without adversely affecting their physical and/or behavioral health. Communication among behavioral health, Nursing Facility staff, and physical health providers is key to accomplishing this goal and ensuring quality of care. This facilitates collaboration among providers, allowing them to work jointly as they coordinate all of the members’ needs efficiently. This collaborative
approach between behavioral health, Nursing Facility staff and physical health providers promotes coordination of care activities.

**Member Access to Behavioral Health Services**

Cigna-HealthSpring members may access behavioral health services in several ways. They are as follows:

1. Through the PCP. A PCP may provide treatment within the scope of his or her practice and licensure using the DSM-V multi-axial classifications.
2. Through a provider referral. A PCP or Specialty Care Provider may refer a Cigna-HealthSpring member to an in-network Behavioral Health provider.
3. Through a self-referral. A member may self-refer for behavioral health services to any in-network Behavioral Health provider. To identify an in-network Behavioral Health provider, members can call their Service Coordinator at 1-877-725-2688. Also, members may call the Cigna-HealthSpring Member Service Department at 1-877-653-0327, Monday through Friday, 8 a.m. to 5 p.m. Central Time. Members in crisis can call Cigna-HealthSpring’s Crisis Hotline at 1-800-959-4941, seven (7) days a week, twenty-four (24) hours per day.
4. Through Service Coordinator referral. New members are assessed by Service Coordinators using the Health Risk Assessment (HRA). All Behavioral Health Referrals and Case Management Services are addressed by the Cigna-HealthSpring Behavioral Health Department. The Behavioral Health Department is comprised of licensed mental health clinicians who are able to assess a member’s needs, assist with accessing services, monitor treatment following discharge from an inpatient facility, assist providers with discharge planning needs, and provide resources for resolving psychosocial needs. A licensed clinician is available to speak with a member or provider to address treatment needs. In addition to licensed clinicians, the Behavioral Health Department includes experienced Behavioral Health Utilization Review Nurses who are responsible for reviewing and authorizing behavioral health services.
5. For the Tarrant SDA, the Behavioral Health Department also includes two co-located clinicians with Tarrant County MHMR who are available to assist with linking members to services provided by the Local Mental Health Authority (MHMR) and coordinating mobile crisis interventions as needed.

**Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM)**

For the purposes of these services Severe and Persistent Mental Illness (SPMI) shall be defined as a mental illness with complex symptoms that require ongoing treatment and management. Severe Emotional Disturbance (SED) shall be defined as a diagnosed condition that disrupts daily functioning.

Provider Requirements and Responsibilities for MHR and TCM Services

- All providers delivering Mental Health Rehab and/or Mental Health Targeted Case Management must undergo all applicable trainings as directed by HHSC before delivering and/or supervising clinicians delivering these services. Providers will be required to attest to Cigna-HealthSpring regarding the completion of these trainings on at least an annual basis, and as requested by
Cigna-HealthSpring. Providers will attest to all trainings using the attestation form provided to them by Cigna-HealthSpring.

- Training courses include, but are not limited to the CANS assessment, ANSA assessment, Illness Management and Recovery, Assertive Community Treatment, Individual Placement and Supports Supported Employment, Permanent Supportive Housing, Social Skills and Aggression Replacement Techniques, Preparing Adolescents for Young Adulthood, Seeking Safety, Nurturing Parenting Program, Barkley’s Defiant Child/Defiant Teen, and Wraparound Planning Process.”

- Services must be authorized using the Department of State Health Services Resiliency and Recover Utilization Management Guidelines (RRUMG)
- Attestation from Provider that organization has the ability to provide, either directly or through sub-contract, the Members with the full array of MHR and TCM services as outlined in the RRUMG.
- Provider must review a Member’s plan of care for Mental Health Rehabilitative Services in accordance with the RRUMG to determine if a change in the Member’s condition or needs warrants a reassessment or change in service. A new plan of care must be submitted to Cigna-HealthSpring for authorization, see Appendices, for review.

Mental Health Rehabilitative Services Qualified Providers
Qualified Mental Health Professionals for Community Services (QMHP-CS). The requirement minimums for a QMHP-CS are as follows.

- Demonstrated competency in the work to be performed; and
- Bachelor’s degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
- Be a Registered Nurse (RN).

A Licensed Practitioner of the Healing Arts (LPHA) is automatically certified as a QMHP-CS. A Community Services Specialist (CSSP), a Peer Provider (PP), and a Family Partner (FP) can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA. Additionally, a PP must be a certified peer specialist, and an FP must be a certified family partner.

Mental Health Targeted Case Management Qualified Providers
A qualified provider of mental health targeted case management must:

- Demonstrate competency in the work performed; and
- Possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
• Be a Registered Nurse (RN).

Individuals authorized to provide case management services prior to August 31, 2004, may provide case management services without meeting the minimum qualifications described above if they meet the following criteria:

• High school diploma or high school equivalency;
• Three continuous years of documented full-time experience in the provision of mental health case management services as of August 30, 2004; and
• Demonstrated competency in the provision and documentation of case management services.
• A case manager must be clinically supervised by another qualified case manager who meets the criteria.

The MCO is prohibited from establishing additional supervisory protocols with respect to the above-listed provider types. Further, the MCO may not require the name of a performing provider on claims submitted to the MCO if that provider is not a type that enrolls in Medicaid (such as CSSPs, PPs, FPs, non-LPHA QMHPs, and Targeted Case Managers).

Freestanding Psychiatric Facilities for Adults in STAR+PLUS
Cigna-HealthSpring is responsible for reviewing and authorizing inpatient Hospital services, including services provided by in a Freestanding Psychiatric Facility.

Prior Authorization Requirements for Behavioral Health Services
Behavioral Health providers should notify Cigna-HealthSpring when they are initiating treatment. The notification process provides an opportunity to verify eligibility, confirm benefits, obtain prior authorization if necessary, and update the member’s electronic file within Cigna-HealthSpring’s system.

The following services do not require prior authorization from Cigna-HealthSpring:

• Medication management – authorization is required after the 30th visit
• Thirty (30) outpatient visits per year – additional outpatient visits require prior authorization

The following behavioral health services require prior authorization from Cigna-HealthSpring:

• In-patient Hospitalization – Cigna-HealthSpring must be notified within one business day of admission
• Partial Hospitalization and Intensive Outpatient Programs – must be authorized before initiating services
• Residential Treatment Services
• Additional outpatient visits, beyond the initial thirty (30) – providers must submit an extended therapy authorization request by the twenty-fourth (24th) visit
• Psychological Testing, Neuropsychological Testing, ECT
• Ambulatory Detox, Residential Detox, Residential Treatment
• Medication Assisted Therapy – notification only
• Mental Health Rehabilitation Services
• Targeted Case Management

Prior authorization forms for behavioral health services can be obtained by visiting our provider portal at https://starplus.hsconnectonline.com (see Appendices for instructions) or calling Provider Services at 1-877-653-0331.

Continuity of Care Follow-Up
When a member does not keep a scheduled appointment, the Behavioral Health provider should contact the member to reschedule the missed appointment within twenty-four (24) hours. Providers should not bill members for missed appointments.

To ensure continuity of care, Cigna-HealthSpring requires its Behavioral Health providers to follow-up with members on an outpatient basis within seven (7) days after discharge from an inpatient setting. Also, Behavioral Health providers should follow-up telephonically or face-to-face with members who are non-compliant with medications and/or treatment. The Cigna-HealthSpring Behavioral Health Department is available to assist with coordinating follow-up appointments following discharge from an inpatient facility.

Medical Record and Documentation
When filing claims for behavioral health services, providers must use the DSM-V multi-axial classification system and report a complete diagnosis using the five (5) Axes. Behavioral health services require the development of a treatment plan. Documentation must always indicate date of service. Co-morbid physical health conditions should be noted in Axis 3 of the diagnosis.

Pharmacy Benefits
Prescription Drug Coverage
Cigna-HealthSpring STAR+PLUS members who are not covered by Medicare are eligible for unlimited prescription drug coverage as described under the Texas Medicaid Formulary. Dual eligible members do not receive prescription drug coverage through the Texas Medicaid Program because coverage is available through Medicare Part D. Additional information about prescription drug coverage for STAR+PLUS members is discussed in greater detail later in this section of the Cigna-HealthSpring provider manual.

Emergency Prescription Supply
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. Additional information about emergency prescription drug coverage for STAR+PLUS Members is discussed in greater detail later in the Emergency Services section of the Cigna-HealthSpring Provider Manual.

Lock-In Program
The Office of Inspector General has established a Lock-in/Limited Program to help address recipient fraud, waste and abuse by restricting Medicaid and/or Managed Medicaid recipients to a designated pharmacy for their prescription needs and services. The table below defines the parameters used to evaluate the appropriateness of placing a recipient into the program. The initial timeframe for the lock-in status is 36 months. This lock-in status stays with the recipient regardless of the MCO or Medicaid eligibility status changes.
Cigna-HealthSpring utilizes the Texas Vendor Drug Program formulary for STAR+PLUS members. Providers can access information about the Texas Vendor Drug Program, including how to find a list of covered drugs, the preferred drug list and formulary alternatives at http://txvendordrug.com/formulary/formulary-search.asp. Cigna-HealthSpring requires some drugs to have a clinical edit. This means certain clinical criteria must be met before coverage will be provided. Cigna-HealthSpring utilizes the Texas Vendor Drug Program clinical edits for STAR+PLUS members. A list of clinical edits can be found at http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml. The Texas Vendor Drug Program Help Desk can be reached at 800-435-4165.

**Formulary**

Cigna-HealthSpring utilizes the Texas Vendor Drug Program formulary for STAR+PLUS members. Providers can access information about the Texas Vendor Drug Program, including how to find a list of covered drugs, the preferred drug list and formulary alternatives at http://txvendordrug.com/formulary/formulary-search.asp. Cigna-HealthSpring requires some drugs to have a clinical edit. This means certain clinical criteria must be met before coverage will be provided. Cigna-HealthSpring utilizes the Texas Vendor Drug Program clinical edits for STAR+PLUS members. A list of clinical edits can be found at http://www.txvendordrug.com/dur/clinical-edit-criteria.shtml. The Texas Vendor Drug Program Help Desk can be reached at 800-435-4165.

**How to File a Coverage Determination**

A Coverage Determination (CD) is any decision that is made by or on behalf of a Medicaid plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled. Coverage Determinations may be received orally or in writing from the Member’s prescribing physicians.

For the provider call center, please call: 888-671-7379 8 a.m. CST to 6 p.m. CST Monday through Friday or fax: 888-766-6341. Forms are available online at http://starplus.cignahealthspring.com/SPPharmacy

The mailing address is:
Medicaid Coverage Determination and Exceptions
PO Box 20002
Nashville, TN 37202.
A provider will receive the outcome of a Coverage Determination by fax no later than twenty-four (24) business hours after receipt of requests or receipt of the supporting statement.

**Emergency Prescription Supply**
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. Additional information about emergency prescription drug coverage for STAR+PLUS Members is discussed in greater detail later in the Emergency Services section of the Cigna-HealthSpring Provider Manual.

Providers can prescribe and obtain long-acting reversible contraception (LARC) products that are on the Texas Medicaid and Texas Women’s Health Program (TWHP) drug formularies from certain specialty pharmacies for women participating in Texas Medicaid and TWHP. LARC products are only available through a limited number of specialty pharmacies that work with LARC manufacturers. Providers who prescribe and obtain LARC products through the specialty pharmacies listed will be able to return unused and unopened LARC products to the manufacturer's third-party processor.

The following products are currently available through the pharmacy benefit:

- Mirena® (NDC 50419042101)
- Mirena® (NDC 50419042301)
- Skyla® (NDC 50419042201)
- Nexplanon® (NDC 0052433001)
- Paragard® (NDC 51285020401)

For a list of specialty pharmacies available to dispense LARC products, please call Cigna-HealthSpring’s Pharmacy Services Department at (888)671-7379.

Providers may also continue to obtain LARC products through the existing buy-and-bill process.

**Enhanced STAR+PLUS Benefits**
Under the STAR+PLUS program, Cigna-HealthSpring members have access to the following benefit, above and beyond what is available under the traditional fee-for-service Medicaid program.

**Value-Added Services**
In addition to traditional STAR+PLUS benefits, Cigna-HealthSpring offers certain “value-added” services to its members. Value-added services are benefits that only Cigna-HealthSpring’s STAR+PLUS members receive. These benefits have been added to Cigna-HealthSpring’s STAR+PLUS program in order to promote healthy lifestyles and improve health outcomes for members.

Initially, Cigna-HealthSpring notifies new members in the Welcome Kit regarding the available value-added services and how to access them. Thereafter, Cigna-HealthSpring sends benefit
education materials to members annually, outlining the available value-added services and how to access them. Additional details about value-added services are available at http://starplus.mycignahealthspring.com/. Cigna-HealthSpring members can get assistance accessing value-added services from their Service Coordinator by calling 1-877-725-2688 or by calling Member Service at 1-877-653-0327.

<table>
<thead>
<tr>
<th>Medicaid ONLY Members</th>
<th>ALL Members</th>
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<tbody>
<tr>
<td>Dental Services</td>
<td>Cigna-HealthSpring Fitness Plus- Active &amp; Fit Home Fitness Kit</td>
</tr>
<tr>
<td>Adults, age 21 and over</td>
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<tr>
<td>Enhanced Vision Services</td>
<td>Reacher/Grabber</td>
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<tr>
<td>Adults, age 21 and over</td>
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<tr>
<td>Good Health Reward</td>
<td>Fleece Lap Blanket</td>
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<tr>
<td>$20 gift card for annual well visit or Texas Health Steps checkup and certain labs or immunizations</td>
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<tr>
<td>$20 gift card for Female Members that complete a recommended mammogram</td>
<td>Cold &amp; Flu Kit</td>
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<tr>
<td>Diabetic Members will receive a $20 gift card for completing a recommended HbA1c lab test each year. Adults age 18 to 75</td>
<td>Hygiene Kit</td>
</tr>
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<td></td>
<td>Clip on Lamp</td>
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**Non-Medicaid Managed Care Covered Services (Non-Capitated Services)**

Non-Medicaid Managed Care Covered Services, or Non-Capitated Services, are services that are covered benefits under the STAR+PLUS program, but they are excluded from HHSC's payments to STAR+PLUS MCOs. Instead of being managed and paid for by the MCOs, Non-Capitated Services are paid through HHSC's Administrative Contractor. This includes things like transportation, immunizations, and hospice services. Even though Cigna-HealthSpring does not pay claims for these services directly, Cigna-HealthSpring coordinates these essential components of the member’s benefit package. By integrating Non-Capitated Services with physical, behavioral, and long term support services, Cigna-HealthSpring can offer a full complement of medically necessary services and achieve optimal care coordination. The Provider should also refer to Texas Medicaid Provider Procedures Manual (TMPPM) for additional information. Non-Capitated Services include the following:

- Behavioral Health Services in the Dallas SDA (will be delivered through fee-for-service)
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Hospice services provided by Home and Community Support Service Agencies contracted with the Department of Aging and Disability Services (DADS)
- Preadmission Screening and Resident Review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by DADS-contracted local authority (LA) and DSHS-contracted local mental health authority (LMHA). Specialized services provided by the LA include: service coordination, alternate placement, and vocational training. Specialized services provided by the LMHA include mental health rehabilitative services and targeted case management. Specialized services provided by a NF for individuals identified as IDD include physical therapy, occupational therapy, speech therapy, and customized adaptive aids. All PASRR specialized services are non-capitated, fee-for-service.
- Long term services and supports for individuals who have intellectual or developmental disabilities provided by DADS contracted providers.

**Emergency Services**

**Definitions:**
The following are definitions for routine, urgent, and emergent care:

**Routine care**
Routine care means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

**Urgent Condition**
Urgent condition means a health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four (24) hours by the member’s PCP or PCP designee to prevent serious deterioration of the member’s condition or health.

**Emergency Services**
Emergency Services are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services. Emergency care is covered for Cigna-HealthSpring members twenty-four (24) hours a day, seven (7) days a week. Prior authorization is not required for Emergency Services.

**Emergency Behavioral Health Condition**
Emergency Behavioral Health means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (1) requires immediate intervention and/or medical attention without which members would present an immediate danger to themselves or others, or (2) which renders members incapable of controlling, knowing or understanding the consequences of their actions.
**Emergency Medical Condition**

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in: (1) placing the patient’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Except for Emergency Services, members are encouraged to contact their PCP prior to seeking care. In the case of an Emergency Medical Condition, a Cigna-HealthSpring member may access care at any provider office or hospital. Members should contact Cigna-HealthSpring or their PCP by the close of the next business day to notify Cigna-HealthSpring of the Emergency Medical Condition.

**Emergency Prescription Supply**

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 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.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member’s medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

1. Place an "8" in "Prior Authorization Type Code" (Field 461-EU).
2. Ensure that "8Ø1" is in "Prior Authorization Number Submitted" (Field 462-EV).
3. Also be sure a "3" is in "Days Supply" (in the claim segment of the billing transaction) (Field 4Ø5-D5).
4. The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber.
5. If the medication is a dosage form that prevents a three-day supply from being dispensed (e.g., an inhaler, eye or ear drops, or creams) it is permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispensed.

Call Provider Services at 877-653-0331 for more information about the 72-hour emergency prescription supply policy.
Emergency Transportation
When a member has an Emergency Medical Condition as defined above, emergency transportation is covered at the basic life support (BLS) level. Prior authorization from Cigna-HealthSpring is not required for emergency transportation. Facility-to-facility transport may be considered an emergency if the emergency treatment is not available at the first facility and the member still requires Emergency Services.

Emergency Dental Services
Cigna-HealthSpring is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:
- Alleviation of extreme pain in oral cavity associated with serious infection or swelling
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration)
- Open or closed reduction of fracture of the maxilla or mandible
- Repair of laceration in or around oral cavity
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts
- Incision and drainage of cellulitis
- Root canal therapy. Payment is subject to dental necessity review and pre- and post-operative x-rays are required
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip

Medicaid Non-Emergency Dental Services:
Cigna-HealthSpring is not responsible for paying for routine dental services provided to Medicaid members.

Cigna-HealthSpring is responsible, however, for paying for treatment and devices for craniofacial anomalies.

Members do have access to value added dental services, which are detailed in the value add grid of the Member Handbook.

Non-Emergent Ambulance Transportation
The Nursing Facility is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the Nursing Facility unit rate. Transports of Nursing Facility residents for rehabilitative treatment (e.g., physical therapy), to outpatient departments, or to physicians’ offices for recertification examinations for Nursing Facility care are not reimbursable services by Cigna-HealthSpring.
Cigna-HealthSpring is responsible for authorizing non-emergency ambulance transportation for a resident whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

**Prior Authorizations for STAR+PLUS Members Residing in a Nursing Facility**

Nursing facility providers must follow the steps below to obtain prior authorizations for non-emergency ambulance transportation for STAR+PLUS members:

1. A physician or physician extender writes an order for non-emergency transport.
2. NF staff should contact the member’s MCO member services line, utilization management department, or service coordinator to find an ambulance company that is in-network.
3. NF staff contacts the ambulance company to get their necessary information to complete the prior authorization form. Necessary information supplied by the ambulance company is limited to company name, fax number, NPI, and other business information.
4. The ambulance provider will document the request was initiated by NF staff and include name, time, and date.
5. The NF must sign and submit the form to the MCO for approval, along with documentation to support medical necessity. The MCO will provide notice of approval/denial to the NF and ambulance provider. If a request for recurring transports is approved, the MCO will include the number of one way transports in the approval.
6. The ambulance company and NF will coordinate the scheduling of the appointment.

Please note that all MCOs will accept the Texas Department of Insurance Standard Prior Authorization form; however, each MCO may have its own forms and methods for submission for prior authorizations, but the steps should remain the same for communication between NF and ambulance providers.

**Durable Medical Equipment and Other Products Normally Found in a Pharmacy**

Cigna-HealthSpring reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy and not covered under the nursing facility unit rate. DME covered under the Nursing Facility unit rate includes: medically necessary items such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as cannulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators).

**STAR+PLUS Eligibility & Enrollment**
STAR+PLUS Eligibility

Determination of eligibility is made by HHSC using the criteria below:

- People who have a physical or mental disability and qualify for supplemental security income (SSI) benefits or for Medicaid due to low income.
- People who qualify for Community-Based Alternatives (CBA) HCBS STAR+PLUS waiver services.
- People age 21 or older who can receive Medicaid because they are in a Social Security Exclusion program and meet financial criteria for HCBS STAR+PLUS waiver services.
- People age 21 or older who are receiving SSI.
- People who are eligible for services under the Community Living Assistance and Support Services (CLASS) waiver, Deaf Blind with Multiple Disabilities (DBMD) waiver; Home and Community-Based Services (HCS) waiver and the Texas Home Living (TxHmL) waiver

To be eligible for NF services, a STAR+PLUS member must meet ALL of the following:

- a physician certifies the member’s medical condition,
- the member’s medical condition requires daily skilled nursing care,
- the member’s medical condition meets medical necessity (MN) requirements,
- the member has received a Preadmission Screening and Resident Review (PASRR) by the local authority (LA) (see Preadmission Screening and Resident Review Referral Policy MCAID-TXSP-HS-SC-P00X), and
- The member has received a Minimum Data Set (MDS) evaluation by the NF to determine the member’s Resource Utilization Group (RUG).
- The need for custodial care alone does not constitute MN for Nursing Facility placement.

Certain Medicaid Members are excluded from enrolling in STAR+PLUS. This includes:

- Members who reside in State Supported Living Centers (SSLCs)
- Members not eligible for full Medicaid benefits, such as Frail Elderly program members, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualified Disabled Working Individuals and undocumented aliens.
- Children in state foster care.
- People not eligible for Medicaid
- Undocumented immigrants

Enrollment

Once a Medicaid Member is determined by HHSC to be eligible for STAR+PLUS, he/she will receive an enrollment packet in the mail from HHSC’s administrative services contractor, MAXIMUS. The packet contains information about the STAR+PLUS program, instructions for completing the enrollment form, and information about the MCOs available in his/her Service Area. MAXIMUS processes STAR+PLUS applications, assists members who are transitioning from traditional fee-for-service Medicaid into the STAR+PLUS Program, and assists members in selecting an MCO. They can also assist Medicaid Only members when choosing a PCP.
Members who need assistance can contact an enrollment counselor by calling the MAXIMUS Helpline at 1-800-964-2777.

Because STAR+PLUS members may change health plans, lose Medicaid eligibility, or change PCPs routinely, it is crucial for providers to verify member eligibility prior to rendering services. If a provider does not verify eligibility prior to rendering services and the member is determined later not to be a Cigna-HealthSpring member, then Cigna-HealthSpring cannot reimburse the provider for his/her services. Eligibility verification prior to every visit is essential to ensuring providers receive payment for services rendered. It is recommended to verify eligibility every first of the month since members can switch health plans every month.

**Verifying Member Medicaid Eligibility**

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the resident has current Medicaid coverage. Providers should verify the resident’s eligibility for the date of service prior to services being rendered. There are several ways to do this:

- Call Cigna-HealthSpring or check our provider HSConnect provider portal
- Use LTC TexMedConnect on the TMHP website at [www.tmhp.com](http://www.tmhp.com)
- Other Options:
  - AIS line
  - Call the Your Texas Benefits provider helpline at 1-855-827-3747.
  - Swipe the resident’s Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.

- Your Texas Benefits Medicaid Card
- Temporary ID (Form 1027-A)
- MCO ID Card
- If the member gets Medicare, Medicare is responsible for most primary, acute, and behavioral health services. Therefore, the Primary Care Provider's name, address, and telephone number are not listed on the member's ID card. The member receives long-term services and supports through Cigna-HealthSpring, and acute services through Medicare.
- Important: Residents can request a new card by calling 1-855-827-3748. Medicaid members also can go online to order new cards or print temporary cards at [www.YourTexasBenefits.com](http://www.YourTexasBenefits.com)

**Your Texas Benefits gives providers access to Medicaid health information**

Medicaid providers can log into the site to see a patient’s Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the ‘Initial Registration Guide for Medicaid Providers’. For more information on how to get registered, download the 'Welcome Packet' on the home page. YourTexasBenefitsCard.com allows providers to:
- View available health information such as:
  - Vaccinations
  - Prescription drugs
  - Past Medicaid visits
  - Health Events, including diagnosis and treatment, and
  - Lab Results
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Use the Blue Button to request a Medicaid patient’s available health information in a consolidated format.

Patients can also log in to [www.YourTexasBenefits.com](http://www.YourTexasBenefits.com) to see their benefit and case information; print or order a Medicaid ID card; set up Texas Health Steps Alerts; and more. If you have questions, call 1-855-827-3747 or email ytb-card-support@hpe.com.

**Verifying Eligibility**

Eligibility can be verified in a variety of different ways: through member identification cards, through Cigna-HealthSpring’s provider portal at [https://starplus.hsconnectonline.com](https://starplus.hsconnectonline.com) (see Appendices for instructions) or telephone verification process, or through State sources such as the Automated Inquiry System (AIS) and TexasMedConnect.

**Cigna-HealthSpring Member Identification Cards**

Cigna-HealthSpring issues an identification card (ID) to all members within five (5) days of receiving State eligibility files. This card identifies the member as a Cigna-HealthSpring member. Also, it gives providers quick access to important information such as the member’s name and identification number, the PCP's name and phone number, the Cigna-HealthSpring claims filing address, and the phone number for prior authorizations and Member Service. Providers should ask members to present this ID card at the time of service. An example of the Cigna-HealthSpring ID card is provided in Appendices of this provider manual.

**The Texas Benefits Medicaid Card and Form 1027-A (Temporary Medicaid Identification)**

In addition to a Cigna-HealthSpring ID card, all members should have a Texas Benefits Medicaid Card from the Texas Department of Health and Human Services Commission or a Form 1027-A (Temporary Medicaid Identification Form). The Texas Benefits Medicaid Card indicates a member’s eligibility dates, and the member’s Medicaid identification number. Form 1027-A is a Temporary Medicaid Identification Form and it is issued prior to issuance of a Texas Benefits Medicaid Card. When a member presents for services, providers should make a copy of all identification cards and keep them on file. An example of the Texas Benefits Medicaid Card and Form 1027-A are provided in Appendices of this provider manual.

**Telephonic and Electronic Eligibility Verification**

Once the provider has made a copy of the member’s identification cards, the next step is to verify eligibility telephonically or electronically. As mentioned previously, members can change PCPs anytime and change MCOs monthly, resulting in member identification cards being outdated almost as soon as they are printed. Telephonic and electronic verification give providers access
to “real time” eligibility information and provide another level of assurance that the provider’s
claim can be processed quickly.

**Verifying Eligibility through Cigna-HealthSpring**
Providers can call Cigna-HealthSpring at 1-877-653-0331, Monday to Friday, 8 a.m. to 5 p.m.
Central Time, to speak with a representative who can verify eligibility or they can use Cigna-
HealthSpring’s Automated Eligibility Verification Line by calling 1-866-467-3126. This system
is available twenty-four (24) hours a day, seven (7) days a week. A third option for verifying
eligibility through Cigna-HealthSpring is through the provider portal at

**Verifying Eligibility through State Resources**
There are two key state resources for verifying eligibility. These are the Automated Inquiry
System (AIS) and TexMedConnect. AIS is available twenty-four (24) hours per day, seven (7)
days per week. The system can be reached by calling 1-800-925-9126. TexMedConnect is a
free, web-based application provided by TMHP. To submit an eligibility inquiry, the user must
enter the member identification number, date of birth, and social security number. Eligibility
inquiries can be made twenty-four (24) hours per day, seven (7) days per week. To enroll in the
TexMedConnect program, providers can contact TMHP or visit their website at

**Disenrollment**
Member disenrollment from Cigna-HealthSpring may occur if the member:

- Selects another STAR+PLUS MCO
- Moves out of the service area
- Is no longer eligible for STAR+PLUS
- Is discharged from a nursing facility

A member may request a disenrollment through the HHSC Administrative Services Contractor.
If the member contacts Cigna-HealthSpring to request a disenrollment, Cigna-HealthSpring will
direct the member to contact the Medicaid Managed Care Helpline at 1-866-566-8989. If the
member is requesting a disenrollment from receiving managed care services, HHSC will require
that the member provide documentation from his or her PCP indicating sufficiently compelling
circumstances that merit disenrollment. If a member requests a voluntary disenrollment at the
same time he/she files a complaint against Cigna-HealthSpring, the complaint will be processed
separately from the disenrollment request, through the member complaint process.

Cigna-HealthSpring has a limited right to request involuntary member disenrollment.

Additionally, Cigna-HealthSpring may request involuntary disenrollment when there is evidence
of member non-compliance such as:

- The member misuses or loans his/her identification card to another person to obtain
  services
The member is disruptive, unruly, threatening or uncooperative to the extent that his/her membership seriously impairs Cigna-HealthSpring’s or the provider’s ability to provide services to the member or to obtain new members and the aforementioned behavior is not caused by a physical or behavioral health condition

The member is steadfastly refusing to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the MCO to coordinate treatment of the underlying medical condition)

If a provider identifies a non-compliant member, the provider should call the Cigna-HealthSpring Provider Services Department at 1-877-653-0331 to report the concern. Cigna-HealthSpring will research the concern and decide if the situation warrants requesting an involuntary disenrollment through HHSC. Cigna-HealthSpring will document all attempts by the provider and Cigna-HealthSpring to rectify the situation. This may include member education and counseling. Then, Cigna-HealthSpring will submit the documentation to HHSC for review. HHSC's Disenrollment Committee will review the disenrollment request. Within five (5) business days of receipt of all information necessary to complete the review, the Disenrollment Committee will make a final determination regarding the disenrollment request. HHSC will provide the member notice of its determination which will include information about the appeal and Fair Hearing process. Cigna-HealthSpring cannot request a disenrollment based on adverse change in a member’s health status or utilization of services medically necessary for treatment of a member’s condition. Additionally, a provider cannot take retaliatory action against a member who is disenrolled from Cigna-HealthSpring. HHSC will make the final decision on any involuntary disenrollment request by Cigna-HealthSpring.

**Automatic Re-Enrollment**

Members disenrolled due to temporary ineligibility for Medicaid will be automatically re-enrolled with their previously selected MCO and PCP when they regain eligibility status. Temporary loss of eligibility is defined as a loss of eligibility for a period of six (6) months or fewer. Members can opt to change MCOs at the time of automatic re-enrollment or at any other time through MAXIMUS by calling the Medicaid Managed Care Helpline at 1-800-964-2777.

**Span of Eligibility**

Members can change MCOs by calling the Medicaid Managed Care Program Helpline at 1-800-964-2777. Members cannot change health plans while they are in the hospital as a patient.

Members can change MCOs once a month. If a member calls to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If he/she calls after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If the member asks to change plans on or before April 15, the change will take place on May 1
- If the member asks to change plans after April 15, the change will take place on June 1
Members can change PCPs at any time by calling the Cigna-HealthSpring Member Service Department at 1-877-653-0327. PCP changes are effective on the next business day, following a member request.

**Retroactive Eligibility Changes**
Member eligibility is subject to retroactive changes for various reasons. If a member's eligibility in Cigna-HealthSpring is retroactively terminated, the Cigna-HealthSpring claim recovery department will request a refund for all previously paid claims from the provider. It is the provider's responsibility to re-verify eligibility to determine the member's coverage for the date(s) of service in question and then file the claim with the appropriate payer.

**Service Coordination and Disease Management**
Through a specialized care management service called Service Coordination, Cigna-HealthSpring ensures that members are aware of all services that are available to them and that members have a central role in planning and directing their own health care. Service coordination includes:

- Identification of needs, including physical health, mental health services and LTSS
- Development of a service plan to address identified needs
- Assistance to ensure timely and coordinated access to providers and covered services
- Attention to addressing unique member needs

Additionally, the Service Coordinator assists members in accessing social services and other community resources, and other medical services that are not part of the covered benefit set, and are delivered outside of Cigna-HealthSpring, such as:

- Texas agency-administered programs and case management services
- Essential public health services
- Texas Commission for the Blind case management
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Hospice services

**Service Coordinator Assignments**
Cigna-HealthSpring provides a Service Coordinator to all STAR+PLUS members.

The Service Coordination team is the primary point of contact for providers when there are issues or questions about a member. Each nursing facility will have an assigned service coordinator to address all Cigna-HealthSpring member needs in that facility. The MCO service coordinator team will complete an annual comprehensive assessment visit, as well as quarterly re-assessments to update member status and ensure all needs are met.
The nursing facility is responsible for contacting the assigned Service Coordinator within one business day via phone, facsimile, email, or other electronic means whenever the following changes occur:

- A significant, adverse change in the member's physical or mental condition or environment that could potentially lead to hospitalization
- An admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, long term services and supports provider, non-contracted bed, another nursing or long term care facility
- An emergency room visit
- Nursing facility initiates an involuntary discharge of a member from a facility
- Notify MCO SC if member moves into hospice care
- Coordinate with MCO SC to plan discharge and transition from a NF
- Notify MCO SC within 72 hours of member’s death
- Notify MCO SC of any other circumstances such as relocation of residents due to natural disaster
- Provide MCO SC access to facility, NF staff and member’s medical information and records.

When a member's Service Coordinator changes, Cigna-HealthSpring provides written notice to the member within 10 business days. The nursing facility may obtain the name of any member’s assigned Service Coordinator by accessing this information on the provider portal.

Cigna-HealthSpring has administrative staff members who assist the Service Coordinators, but they are not responsible for Service Coordination functions. Their roles are restricted to non-clinical, administrative, and workflow tasks, such as telephone calls, correspondence, and record keeping.

Additionally, CHS conducts needs based assessment when there are changes in a member’s clinical condition or a hospitalization.

**Facilitation of Services through the Service Coordinator**

Once a care plan is established, the Service Coordinator works with the member’s PCP and the nursing facility staff to facilitate services, including access to Specialty Care Providers. At the member’s discretion, and with the Specialty Care Provider’s approval, the Specialty Care Provider may be designated as the member’s PCP. Authorization for office visits to an in-network Specialist is not required. Providers and members can reach the Cigna-HealthSpring Service Coordination Department by dialing 1-877-725-2688.

**Role and Responsibilities of NF Staff**

The NF staff will coordinate with the MCO Service Coordinator regarding any care or treatment needs, in order to ensure that member needs are met and that continuity of care is optimized.
**Disease Management (DM)**

Cigna-HealthSpring provides Disease Management (DM) services for STAR+PLUS members with asthma, diabetes, chronic heart failure (CHF), coronary artery disease (CAD), congestive obstructive pulmonary disease (COPD), end-stage renal disease (ESRD), obesity and certain behavioral health conditions. DM is a fully-integrated component within Health Services, and Disease Management staff work closely with members’ assigned Service Coordinators to ensure that all services the member needs to achieve optimal health status are in place and accessible to the member. Members engaged in DM receive individualized care planning and interventions in parallel with any LTSS service coordination that they might be receiving.

The DM program includes the regular assessment of:

- Member needs
- Member education
- Health promotion and wellness
- Review of service utilization
- Analysis of health outcomes
- Documentation of interactions and interventions
- Clinical and behavioral health rounds
- Interdisciplinary care team meetings where the provider is a valued participant

Service Coordinators and Disease Management staff works in conjunction with members to ensure that members have a clear understanding of the symptoms and management of their conditions, medication regimens and compliance, and access to required providers, services and therapies.

**Care Plans**

A care plan for each CHS member is developed by the assigned service coordinator in collaboration with the member, family, and Nursing Facility staff. The care plan addresses each member’s unique LTSS, and behavioral health needs. It incorporates all assessment outcomes, Service Coordinator and behavioral health notes, and any available treatment and diagnostic data. Cigna-HealthSpring’s policy is to use all reasonable efforts to limit access to members’ Personal Health Information to the minimum necessary required to complete a task.

**Discharge Planning**

The Texas Health And Human Services Commission (HHSC) requires that Cigna-HealthSpring and its providers comply with quality measures published in the Texas Uniform Managed Care Manual as well as generally accepted standards governing safe hospital discharge. Completed discharge instructions as shown to the member must be faxed to Cigna-HealthSpring at the time of discharge to fax number (877) 809-0786. Please see Medical Management/Utilization Management Section.

Service Coordination and Utilization Management staff collaborates with the inpatient provider to ensure that all services needed by the member at discharge are in place to allow for a smooth transition from hospital back to the nursing facility. Service Coordination staff, Behavioral Health Case Managers or Disease Management staff follow up with the Nursing Facility staff.
within three business days of discharge to ensure that all needs are being met and arrange for any additional services that member needs to continue recuperating and to avoid readmission.

**Transition Plan**
If the member wishes to transition back into the community and his/her medical condition and informal supports permit, the Service Coordinator will work with nursing facility staff, member, family and health care providers to develop a transition plan. **Informal supports consist of family members, friends, and community resources.**

**Promoting Independence Initiative**
Cigna-HealthSpring participates in the Texas Promoting Independence Initiative. The service coordinator will be the point of contact for any member who may be able to return to the community through STAR+PLUS waiver services. This will include the development and approval of a written plan of care for safely moving into a community setting.

**Medical Management/Utilization Management**
Cigna-HealthSpring is certified by the State of Texas as a Utilization Review Agent (URA) to perform medical management functions for members enrolled in the Cigna-HealthSpring STAR+PLUS program. Cigna-HealthSpring coordinates physical and behavioral health services to ensure quality, timely, clinically-appropriate, and cost-effective care that results in clinically desirable outcomes. Cigna-HealthSpring’s goal is to improve members' health and well-being through effective ambulatory management of chronic conditions, resulting in a reduction of avoidable inpatient admissions.

**Authorizations Process for Nursing Facility Add-on Services**
In the past the nursing facility would request authorization, obtain approval, contact an outside agency to perform/provide the service and the nursing facility would bill for those services. Under managed care, the nursing facility only requests add-on services they are providing and billing for. Outside agencies will request their own authorizations, provide the clinical information supporting the need for the service and bill accordingly.

Cigna-HealthSpring is responsible for reviewing authorizations for services considered Add-Ons per the Long-Term Care Bill Crosswalk issued by DADS. You can refer to [http://www.dads.state.tx.us/providers/hipaa/billcodes/index.html#ltc](http://www.dads.state.tx.us/providers/hipaa/billcodes/index.html#ltc) for billing code information. Providers can contact the Cigna-HealthSpring Provider Services Department at 1-877-653-0331 for additional information.

The grid below is a list of most commonly requested services, (not a complete list). Please refer to the Appendices, List of Prior Authorization Services – Acute, Long Term Support Services (LTSS) and Behavioral Health Services. Providers can also contact Cigna-HealthSpring Provider Services Department at 1-877-653-0331 for additional questions regarding authorizations.
<table>
<thead>
<tr>
<th>Health Services</th>
<th>Prior Authorization Required</th>
<th>Benefit Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Laboratory</td>
<td>No</td>
<td>Lab completed at an out of network nursing facility will require authorization</td>
</tr>
<tr>
<td>Mobile Radiology</td>
<td>No</td>
<td>MRI, PET, CT, MRA will require an authorization regardless of location.</td>
</tr>
<tr>
<td>Emergency dental services</td>
<td>Yes</td>
<td>Dental procedures performed in an office need authorization with DentaQuest. Emergency dental situations requiring hospitalization require an authorization. For emergency services, please request authorization the next business day.</td>
</tr>
<tr>
<td>Customized power wheel chairs</td>
<td>Yes</td>
<td>Refer to section Customized Power Wheelchair (CPWC) for criteria. The request must also meet medical necessity criteria.</td>
</tr>
<tr>
<td>Physician-ordered rehabilitative services: PT, OT, ST</td>
<td>Yes</td>
<td>Initial Evaluations, there is no authorization is required. Any visit after that will require an authorization. The request must meet medical necessity criteria. Refer to section PT, ST, OT add-on services for more information.</td>
</tr>
<tr>
<td>Augmentative communication devices</td>
<td>Yes</td>
<td>The request must meet medical necessity criteria. Refer to section Augmentative Communication Device (ACD).</td>
</tr>
</tbody>
</table>

**Utilization Review Criteria and Authorization Process**

For services that do require CHS to review for authorization, an authorization request form will be completed and faxed into the Utilization Management department. Texas Standard Prior Authorization form located in Appendixes of this manual is the preferred authorization form. However, other authorization forms will be accepted. Authorization forms can also be found on our website at: http://starplus.cignahealthspring.com. The intake staff will enter the data into the documentation system and assign to a UM nurse to review. Using an evidenced-based medical necessity criteria tool, and/or other approved review criteria, the nurse will review the clinical information provided to establish medical necessity for the item/service. If the nurse can approve, an authorization approval letter will be sent to the servicing provider. If the UM nurse is unable to approve the service/item request with the clinical information provided, the UM nurse will send the request to the medical director for determination. The medical director will determine the medical necessity of the request. For STAR+PLUS, the determination will be communicated to the servicing provider. For in-network providers, the turnaround time from receipt of the request to determination is three business days. It is critical that Cigna-HealthSpring receives the necessary clinical to make a determination in a timely manner. For STAR+PLUS members, an administrative denial will be issued for lack of clinical information. The UM nurses communicate with the assigned Service Coordinator as indicated.
Cigna-HealthSpring requires the Nursing Facilities to submit a Resident Transaction Form 3618 and/or Form 3619 to HHSC as timely as possible. Filing these forms updates eligibility on the file the MCO receives from the state showing if the member has returned to the community or has entered a nursing facility.

**Urgent Request**
An urgent request can be requested if/when the provider believes that waiting for a decision under the standard request timeframe could place the member’s life, health, or ability to regain maximum function in serious jeopardy. For these cases, providers may make an urgent request. If Cigna-HealthSpring confirms the situation is truly urgent, Cigna-HealthSpring will respond within one (1) business day.

**Emergency Room Admissions**
Prior authorization is not required for Emergency Room Services. However, providers must notify Cigna-HealthSpring if the member was admitted after an emergency room visit by the next business day.

**Post-Stabilization Request**
Post-stabilization requests can be made for covered services related to an Emergency Medical Condition provided after a member has been stabilized. These are services to maintain the stabilized condition or, under certain circumstances, are not pre-approved but are administered to maintain, improve, or resolve the member’s stabilized condition. Cigna-HealthSpring will respond to post-stabilization requests within one (1) hour.

**Authorization Denials**
If the request for authorization does not meet medical necessity requirements, the request may be denied. The servicing provider will be notified of the denial by fax or phone and in writing. The member will be notified of the denial in writing. For STAR+PLUS, the ordering provider will be offered an opportunity for a peer-to-peer conversation with a Cigna-HealthSpring Medical Director.

**Inpatient Authorization (Initial and Concurrent)**
Initial Review: The hospital will be required to obtain an authorization for all inpatient admissions; scheduled and unscheduled. Many members are admitted through the emergency room. If the member is admitted into observation status at an in-network hospital, an authorization is not required. However; should the member be admitted inpatient, then an authorization is required. Providers are required to provide Cigna-HealthSpring with notification of the following types of admissions:

- Elective Admissions
- Emergency and Urgent Inpatient Admissions
- Admissions following outpatient procedures
- Admissions following Observation Status
- All inpatient physical and behavioral health admissions
- All out of network services.
Notifications must be made by the next business day. If the admission occurs during a holiday or weekend, then notification must be made by close of the next business day. Admission notification may be made by calling Cigna-HealthSpring’s Health Services Department at 1-877-562-4402 and following the prompts to speak with the Inpatient Intake Unit or by faxing an Inpatient Prior Authorization Form to 1-877-809-0786 or by using on the Provider portal. The "Inpatient Prior Authorization Request Form" can be found in Appendices of this provider manual.

**Failure to Obtain an Authorization**
Failure to obtain prior authorization for services that require authorization may result in non-payment of services. It is important to note that authorization does not guarantee payment. An authorization addresses the medical necessity of a service, procedure, admission, etc. Eligibility and coverage are separate and distinct issues.

**Direct Access Services**
Cigna-HealthSpring STAR+PLUS and MMP members may access any specialist without a referral from their PCP as long as they are in-network with Cigna HealthSpring STAR+PLUS. Please note that some specialists require a referral from a PCP before they will consider seeing a member. Some specialists want to review clinical information on the member prior to accepting them for care.

**Out-of-Network Authorizations**
All non-emergent, out-of-network services require prior authorization outside of the nursing facility. The provider rendering the services is responsible for obtaining an authorization. Once an out-of-network request is received, Cigna-HealthSpring must investigate to see if there is an in-network provider that can provide the services being requested. Cigna-HealthSpring’s goal is to transition and/or direct the member to an in-network provider. If an in-network provider is available, then a provider may choose to rescind the request or may request a formal denial.

**Continuity of Care**
Cigna-HealthSpring ensures that new Members transition smoothly into Cigna-HealthSpring and that care is not interrupted unnecessarily. The following circumstances are considered to ensure continuity of care and to ensure their health is not jeopardized:

MCO must ensure members receiving add-on services through a prior authorization from either another MCO or Fee-For-Service receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

- 90 calendar days after transition to new MCO
- Until the end of the current authorization period
- Until the MCO has evaluated and assessed the member and issued or denied a new authorization

If notification is not provided according to the guidelines above, authorization will not be granted and claims for services will be denied. Claim denials for no authorization may be appealed and will be subject to retrospective medical review. It may be necessary to provide
documentation of the reason for failing to provide timely notification as well as clinical documentation.

If the member is hospitalized at the time they enroll with Cigna-HealthSpring, we will work to ensure the member’s hospital stay is covered by the responsible party. If the member is hospitalized at the time they dis-enroll from Cigna-HealthSpring, Cigna-HealthSpring will pay for the hospitalization as long as it is medically necessary until the member is discharged.

Cigna-HealthSpring will work with the member if they should decide to transfer facilities to ensure payment continues for their Nursing Facility Care.

If the member is pregnant when they enroll with Cigna-HealthSpring, and the member is past the 24th week of pregnancy, Cigna-HealthSpring will allow the member to remain under the current OB/GYN care until they have had your post-partum checkup, even if the provider is out of network.

If the member moves out of Service Area, Cigna-HealthSpring will provide or pay providers in the New Service Area for medically necessary services through the end of the period the member remains enrolled. Members who move out of the Service Area are responsible for obtaining a copy of their medical records from their current provider on behalf of their new PCP. Participating Cigna-HealthSpring providers are required to furnish members with copies of their medical records.

If the member has any preexisting condition, Cigna-HealthSpring will pay for all medically necessary services at the beginning of the time the member enrolls, regardless of the conditions.

Note: Providers cannot appeal a denial for a medical service. Providers can only appeal denied claims. The Provider can act as an authorized representative to appeal on the member’s behalf as long as he/she has written consent from the member or the member can appeal by completing a member appeal form.

**Billing and Claims Administration**

**Claims Submission for Unit Rate Services or Medicare Coinsurance**

There are three ways to file a claim:
1. **Electronically** (Payer ID #52192) – via 1 of the following 3 Cigna-HealthSpring claims clearing houses: (1) Change Healthcare (formerly Emdeon), (2) PayerPath, or (3) Availity
2. **Via secure Provider Portal** – for 837I, 837P or direct data entry CMS1500 or UB-04 claim form submission through HSCConnect at [https://starplus.hsconnectonline.com](https://starplus.hsconnectonline.com)
3. **Via TMHP State’s website** – Visit the website http://www.tmhp.com/ and click on ‘Providers’ in the top header. Then Click ‘Go to TexMedConnect’ in the upper right corner.

**Dental services** – Electronically with DentaQuest-Claims. Change Healthcare (formerly Emdeon)/Availity Payer ID: CX014.

**Claim Submission Requirements**
This section contains claim filing reminders and instructions for the completion of a UB-04 claim form. Although this section references how to file a paper claim, many of the same requirements apply to claims submitted electronically. For providers billing add-on services, refer to our Cigna-HealthSpring STAR+PLUS manual on our website. NFs must file a claim with the MCO for add-on services by the later of: (1) 95 days after the date of service, or (2) 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor.

IMPORTANT NOTE: Although Cigna-HealthSpring follows many of the same claim filing requirements as Texas Medicaid & Healthcare Partnership (TMHP) for FFS Medicaid claim filing, Cigna-HealthSpring is also required to follow additional Federal requirements. These additional Federal requirements may cause differences in claim filing requirements for Cigna-HealthSpring members.

Claim submission requirements apply to all participating and out-of-network providers.

**Claims Addresses**
As indicated in the table below, providers should submit claims based on the type of services provided.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Claims Address</th>
</tr>
</thead>
</table>
| Dental services   | Paper Claims: DentaQuest-Claims  
|                   | 12121 North Corporate Parkway  
|                   | Mequon, WI 53092                                                           |
|                   | Electronic Claims: Change Healthcare (formerly Emdeon)/Availity Payer ID: CX014 |
| Vision services   | Superior Vision  
|                   | Attn: Claims  
|                   | 939 Elkridge Landing Road, Ste 200  
|                   | Linthicum, MD 21090                                                        |
|                   | Electronic Claims: Online via https://www.blockvisiononline.com/login  
|                   | Electronically with Block Vision. RelayHealth Payer ID: 3402               |

For providers billing add-on services, refer to our Cigna-HealthSpring STAR+PLUS manual on our website [http://starplus.cignahealthspring.com/](http://starplus.cignahealthspring.com/) or contact Provider Services at 1-877-653-0331.
Submitted MCO Claims to TMHP for Proper Routing:

- Using TexMedConnect: Log in to the TMHP secure website and submit the claims to TMHP
- Through EDI: Log in to the claims billing software and submit the claims through EDI to TMHP

Note: Each claim must contain services administered by a single entity, either all fee-for-service (including services for fee-for-service Members and carve-out services), all MCO services, or all dental plan services. Fee-for-service procedures and MCO procedures for the same Member cannot be billed on the same claim. Each claim may be submitted individually or in a batch. Each batch may contain claims destined for a variety of plans including fee-for-service and managed care. Providers receive a message that indicates whether the claim was transmitted successfully or unsuccessfully.

Claims Responsibility for Vision and Dental Services

<table>
<thead>
<tr>
<th>Member Coverage</th>
<th>Vision Care Responsibility</th>
<th>Dental Care Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If Primary Payer Is…</strong></td>
<td><strong>And secondary payer is …</strong></td>
<td><strong>Value Added through Cigna-HealthSpring STAR+PLUS</strong></td>
</tr>
<tr>
<td>Cigna-HealthSpring STAR+PLUS</td>
<td>n/a</td>
<td>Cigna-HealthSpring MA-PD</td>
</tr>
<tr>
<td>Cigna-HealthSpring MA-PD (Medicare)</td>
<td>Cigna-HealthSpring STAR+PLUS</td>
<td>Cigna-HealthSpring MA-PD</td>
</tr>
<tr>
<td>Other Payer MA-PD</td>
<td>Cigna-HealthSpring STAR+PLUS</td>
<td>Other Payer MA-PD</td>
</tr>
<tr>
<td>Traditional Medicare</td>
<td>Cigna-HealthSpring STAR+PLUS</td>
<td>Medicare</td>
</tr>
</tbody>
</table>

Claims Filing Deadline for Unit Rate Services and Medicare Coinsurance

Cigna-HealthSpring's claim filing deadline is the same as traditional, fee-for-service Medicaid. Providers must submit claims to Cigna-HealthSpring by the later of: (1) three hundred and sixty-five (365) days after the date of service, or (2) ninety-five (95) days after the date on the remittance and status report or explanation of payment from the other carrier or contractor. If Cigna-HealthSpring is the secondary payer, providers must include the primary payer’s explanation of payment. Nursing Facilities must submit an electronic version of the Medicare Remittance Advice form.

If the claim is not filed with Cigna-HealthSpring within three hundred and sixty-five (365) days from the date of service or ninety-five (95) after the date on the R&S Report or explanation of payment from the primary payer, the claim will be denied.

Clean Claim

A clean claim is a complete and accurate claim form that is submitted for a medical or health care service that includes all provider and member information. A provider submits a clean claim by providing the required data elements on the standard claim form, whether it is a UB-04.
Clean claims are received within three hundred and sixty-five (365) days of the date of service or ninety-five (95) after the date on the R&S Report or explanation of payment from the primary payer. The required data elements for Medicaid claims must be present for a claim to be considered a clean claim by DADS criteria as described in UMCM Chapter 2.3, Nursing Facility Claims Manual”.

A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837-(claim type) encounter guides as follows: (a) 837 Professional Combined Implementation Guide; (b) 837 Institutional Combined Implementation Guide; (c) 837 Professional Companion Guide; and (d) 837 Institutional Companion Guide.

Additional information on clean claim definitions and data elements are provided at Tex. Ins. Code §843, Subchapter J; 28 Tex. Admin. Code §11.901(a)(8); 28 Tex. Admin. Code Chapter 21, Subchapter 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. A corrected claim could be a result of:

- Errors were found involving diagnosis, procedure, date or modifier
- Claims contained missing, incorrect, or incomplete data according to our claims submission requirements
- Services were missed in an original claim
- Original claim billed with incorrect number of units or billed amount
- Adjustments to such things as: Nursing Facility Daily Rates, Provider Contracts, Service Authorizations, Applied Income, and Level of Service (RUG).

Corrected claims must be sent within 120 days of initial claim disposition. Failure to mark the claim as Corrected could result in a duplicate claim and be denied for exceeding the 365 days timely-filing deadline.

**Claim Adjustments**

Cigna-HealthSpring will make adjustments to previously adjudicated claims within 30 days from the date of receipt of an adjustment from the State to reflect changes to such things as: Nursing Facility Daily Rates, Provider Contracts, Service Authorizations, Applied Income, and Level of Service (RUG).

**Claim Filing Formats for Unit Rate Services and Medicare Coinsurance**

Cigna-HealthSpring accepts claims in electronic formats. Electronic claims are the preferred method of submission. Electronic claims can be submitted to Cigna-HealthSpring through Change Healthcare (formerly Emdeon), or TMHP (TexMedConnect/ the TMHP EDI Gateway) or Availity (formerly T.H.I.N.), or PayerPath, or through HS Connect, which is Cigna-HealthSpring’s provider portal.

Electronic claims must be submitted using the HIPAA-complaint American National Standards Institute (ANSI) ASC X12 5010 file format through secure socket layer (SSL) and virtual private
networking (VPN) connections for maximum security. For additional information refer to Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information).

The Cigna-HealthSpring Payer ID is 52192. Questions regarding Change Healthcare (formerly Emdeon) electronic claims submission can be directed to Change Healthcare (formerly Emdeon) at 1-800-845-6592 or providers may refer the Change Healthcare (formerly Emdeon) website at http://changehealthcare.com/. Nursing Facility providers may also submit claims through an HHSC-designated portal.

**Cigna-HealthSpring Provider Portal Claims Submission**

Cigna-HealthSpring’s secure provider portal is available to participating providers only. Providers must have a username and password to access the provider portal. New providers must register a username and password online when accessing the provider portal. Providers can submit a CMS 1500 or UB04 electronic claims through the Cigna-HealthSpring Provider portal, HSConnect, at https://starplus.hsconnectonline.com. Providers can seek assistance with the HSConnect provider portal by calling 1-866-952-7596. Functions of the Provider Portal include:

- Verify member eligibility
- Print PCP rosters
- Submit individual and batch claims
- Check claim status
- Request authorizations
- Check authorization status
- Print Explanations of Payment
- Verify member’s Service Coordinator

**Taxonomy Codes**

**Taxonomy Required on NF Claims**

NFs will be required to enter the appropriate health care Provider Taxonomy Code associated to the National Provider Identifier (NPI) of the billing entity on all Long Term Care (LTC) NF institutional claims submitted to TMHP using TexMedConnect or Electronic Data Interchange (EDI). Taxonomy codes further define the type, classification, and/or specialization of the health care provider. If a provider attempts to submit a claim to TMHP without a valid taxonomy code, regardless of the date of service, the claim will be rejected and providers will receive an error message. According to the Centers for Medicare and Medicaid Services (CMS), all health care providers must select a taxonomy code(s) when applying for an NPI. NF claim submitters should enter the taxonomy code which best describes the service being billed on the claim. The most common NF taxonomy codes are:

- 314000000X = Skilled NFs
- 313M00000X = Other NFs

Providers can access the National Plan & Provider Enumeration System website at https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistrySearch.do?subAction=reset&searchType=ind to determine what taxonomy code(s) are associated with a provider’s NPI.
To obtain additional information about taxonomy codes, providers can visit the CMS website at www.cms.gov.

**National Provider Identification (NPI) Numbers**
A NPI number is a standard, nationally-assigned, “non-intelligent” provider identifier that is required to be used in all electronic health care transactions effective May 27, 2008. Providers who do not have a NPI number can obtain one by calling 1-800-465-3203 (TTY 1-800-692-2326) or by emailing memberservice@npienumerator.com. Providers also may obtain a NPI by writing to NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

After receiving a NPI number, Texas Medicaid providers must "attest" their NPIs and related data to TMHP. Related data includes a taxonomy code and a physical address with a ZIP+4 Codes. During attestation, some providers may also be assigned a benefit code to identify specific state programs as part of their NPI-related data. NPIs can be attested on the TMHP website at http://www.tmhp.com. The information required for attestation includes the provider's:

- TPI
- NPI or API
- Taxonomy
- Physical Address
- National Plan and provider Enumeration System Data

**NPI - Group Providers**
Providers billing as a group must give the performing provider NPI on their claims as well as the group NPI. This requirement excludes THSteps medical providers; see section on claim filing for THSteps services.

**NPI – Supervising Physician Providers**
The supervising provider number is required on claims for services that are ordered or referred by one provider at the direction of or under the supervision of another provider, and the referral or order is based on the supervised provider’s evaluation of the member.

If a referral or order for services to a Texas Medicaid member is based on a member evaluation that was performed by the supervised provider, the billing provider’s claim must include the names and NPIs of both the ordering provider and the supervising provider. The billing provider must obtain all of the required information from the ordering or referring provider before submitting the claim to Cigna-HealthSpring.

All paper claims must be submitted with a Texas Provider Identifier (TPI) and an attested National Provider Identifier (NPI) for the billing and performing providers. All other provider fields on the claim forms require an NPI only. If a NPI and TPI are not included in the billing and performing provider fields, or if a NPI is not included on all other provider identifier fields, the claim will be denied.
Providers billing for LTSS services should refer to the LTSS billing guide for additional information on paper claim submission.

When filing electronic claims, providers must submit their NPI or API number, whichever is applicable, and their taxonomy code. Some LTSS providers are not eligible for a NPI. These providers must request an API number from Cigna-HealthSpring.

**Diagnosis Coding**
Cigna-HealthSpring requires providers to provide *International Classification of Disease, Ninth Revision, Clinical Modification* (ICD-10-CM) diagnosis codes on their claims. Diagnosis codes must be to the highest level of specificity available. All diagnosis codes must be appropriate for the age of the member as identified in the ICD-10-CM description of the diagnosis code. Claims that are submitted without a valid ICD-10 code will be denied. (Block # 67, 67A-67Q, 69, 70A-70C, and 72A-72C - UB-04)

**Present on Admission (POA)**
Present on Admission (POA) is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, and outpatient surgery, are considered POA.

Hospital providers that are reimbursed under prospective payment basis methodology (diagnosis related grouping (DRG) will be required to submit a “present on admission” (POA) value for all diagnoses on inpatient hospital claims. Claims that are submitted without the required POA indicator will be denied. (Block # 67, 67A-67Q – UB-04)

<table>
<thead>
<tr>
<th>POA Value</th>
<th>Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at the time of admission.</td>
<td>Payment will be made by Medicaid when a hospital acquired condition (HAC) is present.</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at the time of admission.</td>
<td>No payment will be made by Medicaid when an HAC is present.</td>
</tr>
<tr>
<td>U</td>
<td>Documentation was insufficient.</td>
<td>No payment will be made by Medicaid when an HAC is present.</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined.</td>
<td>Payment will be made by Medicaid when an HAC is present.</td>
</tr>
</tbody>
</table>

**Supplemental Payments to Non-State Government-Owned Nursing Facilities**
Eligible NFs could apply to participate in this program and, if approved, the NFs could receive supplemental payments based on the difference between the amount paid through fee-for service Medicaid and the amount Medicare would have paid for those same services. As with other supplemental payment programs operated by HHSC, the non-federal share of the supplemental Medicaid payment is funded through intergovernmental transfers (IGTs) provided by the non-state governmental entities that own the participating NFs. Payments have been made under the Nursing Facility Upper Payment Limit (NF UPL) program. NF would have to meet multiple criteria to be eligible for this minimum payment. First, the NF would have to be owned by a non-state governmental entity. Second, the NF would be required to make certain representations and
certifications on a form to be prescribed by HHSC. Third, the NF would be required to provide 
an IGT to make up the non-federal share of the additional payment beyond the expected MCO 
payments. Fourth, the NF would be required to submit an application for approval to receive the 
mandatory minimum payment no later than the date, to be determined by HHSC, by which the 
capitation payment rate to be paid to the MCOs must be determined. Finally, HHSC proposed 
that after a certain point in time, only NFs owned by non-state governmental entities in the same 
or a contiguous county would be eligible to receive the minimum payment. The minimum 
payment would have been made on a quarterly basis with MCOs required to pay qualified NFs in 
two installment payments each quarter. The proposal required the MCO to make the first 
payment no later than ten calendar days after a qualified NF or its agent submitted a clean claim 
for a NF day of service. This first payment was proposed to be made at or above the prevailing 
rate established by HHSC for the date of service. The proposal required the MCO to make the 
second payment, equal to the difference between the first payment and the minimum payment 
amount described in the proposal (essentially the Medicare rate for the same service) for all 
Medicaid days of service provided during the quarter no later than 110 calendar days after the 
end of the quarter. HHSC proposed a 110 calendar day delay between the end of the quarter and 
the second payment to allow qualifying NFs 95 days to submit their claims to qualify for the 
second payment (NFs have up to 365 days to submit claims to qualify for the first payment) and 
the MCO 15 days to calculate and process the second payment.

**Procedure Coding**

Cigna-HealthSpring uses a coding system called Health Care Common Procedure Coding 
System (HCPCS) code set. HCPCS provides health-care providers and payers a common coding 
structure that is designed around a five-character numeric or alphanumeric base for all codes. 
Claims submitted without a valid HCPCS codes will be denied. (Block # 44 – UB-04)

HCPCS consists of two levels of codes including the Current Procedural Terminology (CPT®) 
Professional Edition (Level I) and the HCPCS codes approved and released by CMS (Level II)

**Level I**

CPT® Professional Edition:
- All numeric – consist of five digits
- Represent 80 percent of HCPCS
- Maintenance – responsibility of the AMA, which updates annually
- Updates by the AMA are coordinated with CMS before distribution of modification to 
third party payers
- Anesthesia codes from CPT

**Level II**

HCPCS codes:
- Approved and released by CMS
- Codes for both physician and non-physician services not contained in CPT (for example, 
  ambulance, DME, prosthetics, and some medical codes)
- Updating: Responsibility of the CMS Maintenance Task Force
• All alphanumeric consisting of a single alpha character (A through V) followed by four numeric digits
• The single alpha character represents the following:

<table>
<thead>
<tr>
<th>Alpha</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Supplies, administrative, miscellaneous</td>
</tr>
<tr>
<td>B</td>
<td>Enteral and parenteral therapy</td>
</tr>
<tr>
<td>E</td>
<td>DME and oxygen</td>
</tr>
<tr>
<td>G</td>
<td>Procedures/professional (temporary)</td>
</tr>
<tr>
<td>H</td>
<td>Rehab and behavioral health services</td>
</tr>
<tr>
<td>J</td>
<td>Drugs (administered other than orally) See NDC requirements</td>
</tr>
<tr>
<td>K</td>
<td>Durable Medical Equipment Regional Carriers (DMERC)</td>
</tr>
<tr>
<td>L</td>
<td>Orthotic and prosthetic procedures</td>
</tr>
<tr>
<td>M</td>
<td>Medical</td>
</tr>
<tr>
<td>P</td>
<td>Laboratory</td>
</tr>
<tr>
<td>Q</td>
<td>Temporary procedures</td>
</tr>
<tr>
<td>R</td>
<td>Radiology</td>
</tr>
<tr>
<td>S</td>
<td>Private payer</td>
</tr>
<tr>
<td>T</td>
<td>State Medicaid agency</td>
</tr>
<tr>
<td>V</td>
<td>Vision and hearing services</td>
</tr>
</tbody>
</table>

**National Drug Code (NDC)**

The NDC is an 11-digit number on the package or container from which the medication is administered. If the NDC is indicated on the box, and vial of a medication, enter the NDC from the vial. Providers must submit a NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure.

Codes in the A code series do not require a NDC.

N4 must be entered before the NDC on claims.

The units of measurement codes can also be submitted, however, are not required. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN - Unit

Unit quantities can also be submitted, however, are not required.

Depending on the claim type, the NDC information must be submitted as indicated below for paper claims, or the equivalent electronic field. Claims requiring the NDC, but submitted with an invalid HCPCS-NDC combination, or without the required NDC will be denied.
UB-04 Claim Filing Detail
Below is the minimum data required to process a claim on a UB-04 form. Any missing or invalid data will result in a claim denial. Claim information must match the referral/authorization information.

The UB-04 form is used by the Nursing Facility to file claims for their Daily Unit Rate.
### UB 04 Form Detail

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unlabeled</td>
<td>Enter the hospital name, street, city, state, ZIP+4 Code, and telephone number.</td>
</tr>
<tr>
<td>3a</td>
<td>Patient control number</td>
<td><strong>Optional:</strong> Any alphanumeric character (limit 16) entered in this block is referenced on the R&amp;S Report.</td>
</tr>
<tr>
<td>3b</td>
<td>Medical record number</td>
<td>Enter the patient’s medical record number (limited to ten digits) assigned by the hospital.</td>
</tr>
<tr>
<td>4</td>
<td>Type of bill (TOB)</td>
<td>Enter a TOB code.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>First Digit—Type of Facility:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Skilled nursing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Home health agency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC])</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 Special facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Second Digit—Bill Classification (except clinics and special facilities):</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Inpatient (including Medicare Part A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Inpatient (Medicare Part B only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Outpatient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 Intermediate care</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Second Digit—Bill Classification (clinics only):</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Rural health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Hospital-based or independent renal dialysis center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Free standing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 CORFs</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Third Digit—Frequency:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 Nonpayment/zero claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Admit through discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Interim-first claim</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
|          |                                            | 3 Interim-continuing claim  
4 Interim-last claim  
5 Late charges-only claim  
6 Adjustment of prior claim  
7 Replacement of prior claim                                                                                                                                 |
| 6        | Statement covers period                    | Enter the beginning and ending dates of service billed.                                                                                                                                                   |
| 8a       | Patient identifier                        | **Optional:** Enter the patient identification number if it is different than the subscriber/insured’s identification number.  
Used by providers office to identify internal patient account number.                                                                                                           |
| 8b       | Patient name                              | Enter the patient’s last name, first name, and middle initial as printed on the Medicaid identification form.                                                                                             |
| 9a–9b    | Patient address                           | Starting in 9a, enter the patient’s complete address as described (street, city, state, and ZIP+4 Code).                                                                                                  |
| 10       | Birthdate                                 | Enter the patient’s date of birth (MM/DD/YYYY).                                                                                                                                                           |
| 11       | Sex                                       | Indicate the patient’s gender by entering an “M” or “F.”                                                                                                                                                 |
| 12       | Admission date                            | Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims.  
Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.                                                    |
<p>| 13       | Admission hour                            | Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.                                                                                     |
| 14       | Priority (Type) of Admission or Visit     | Providers can refer to the National Uniform Billing Code website at <a href="http://www.nubc.org">www.nubc.org</a> for the current list of Priority (Type) of Admission or Visit codes.                                      |
| 15       | Point of Origin for Admission or Visit    | Providers can refer to the National Uniform Billing Code website at <a href="http://www.nubc.org">www.nubc.org</a> for the current list of Point of Origin for admission or visit.                                    |</p>
<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Admission or Visit codes.</td>
</tr>
<tr>
<td>16</td>
<td>Discharge hour</td>
<td>For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of “30”), leave the block blank.</td>
</tr>
<tr>
<td>17</td>
<td>Patient Discharge Status</td>
<td>Providers can refer to the National Uniform Billing Code website at <a href="http://www.nubc.org">www.nubc.org</a> for the current list of Patient Discharge Status Codes.</td>
</tr>
<tr>
<td>18–28</td>
<td>Condition codes</td>
<td>Enter the two-digit condition code “05” to indicate that a legal claim was filed for recovery of funds potentially due to a patient.</td>
</tr>
<tr>
<td>29</td>
<td>ACDT state</td>
<td><strong>Optional:</strong> Accident state.</td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence codes and dates</td>
<td>Providers can refer to the National Uniform Billing Code website at <a href="http://www.nubc.org">www.nubc.org</a> for the current list of Occurrence Codes.</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence span codes and dates</td>
<td>For inpatient claims, enter code “71” if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.</td>
</tr>
<tr>
<td>39-41</td>
<td>Value codes</td>
<td>Accident hour–For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.</td>
</tr>
<tr>
<td>42-43</td>
<td>Revenue codes and description</td>
<td>For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence.</td>
</tr>
</tbody>
</table>
List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate.

**NDC**

This block should include the following elements in the following order:

- NDC qualifier of N4 (e.g., N4)
- The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231)
- The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME (e.g., GR).
- The unit quantity with a floating decimal for fractional units (limited to 3 digits, e.g., 0.025).

*Example:* N400409231231GR0.025

*Refer to:* Subsection 6.3.4, “National Drug Code (NDC)” in the TMHP Website.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| 44        | HCPCS/rates | **Inpatient:**

Enter the accommodation rate per day.

Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis.

Each service and supply must be itemized on the claim form.

**Home Health Services**

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description.

*Refer to:* Section 4.5.5, “Outpatient Hospital Revenue Codes” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for additional information on which revenue codes require HCPCS codes in the TMHP website.

**Outpatient:**

Outpatient claims must have the appropriate Healthcare Common
### Block No. Description Guidelines

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Procedure Coding System (HCPCS) code.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Refer to:</strong> <a href="#">Section 4.5.5, “Outpatient Hospital Revenue Codes”</a> in the <em>Inpatient and Outpatient Hospital Services Handbook</em> (<em>Vol. 2, Provider Handbooks</em>) for additional information on which revenue codes require HCPCS codes in the TMHP website.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> The UB-04 CMS-1450 paper claim form is limited to 28 items per inpatient and outpatient claim. If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>45</th>
<th>Service date</th>
<th>Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 (line 23)</td>
<td>Creation date</td>
<td>Enter the date the bill was submitted.</td>
</tr>
<tr>
<td>46</td>
<td>Serv. units</td>
<td>Provide units of service, if applicable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>When billing for observation room services, the units indicated in this block should always represent hours spent in observation.</td>
</tr>
<tr>
<td>47</td>
<td>Total charges</td>
<td>Enter the total charges for each service provided.</td>
</tr>
<tr>
<td>47 (line 23)</td>
<td>Totals</td>
<td>Enter the total charges for the entire claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> For multi-page claims enter “continue” on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>48</td>
<td>Noncovered charges</td>
<td>If any of the total charges are noncovered, enter this amount.</td>
</tr>
<tr>
<td>50</td>
<td>Payer Name</td>
<td>Enter the health plan name.</td>
</tr>
<tr>
<td>51</td>
<td>Health Plan ID</td>
<td>Enter the health plan identification number.</td>
</tr>
<tr>
<td>54</td>
<td>Prior payments</td>
<td>Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 80 as required.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Enter the NPI of the billing provider.</td>
</tr>
<tr>
<td>57</td>
<td>Other identification (ID) number</td>
<td>Enter the TPI number (non-NPI number) of the billing provider.</td>
</tr>
<tr>
<td>58</td>
<td>Insured’s name</td>
<td>If other health insurance is involved, enter the insured’s name.</td>
</tr>
<tr>
<td>60</td>
<td>Medicaid identification number</td>
<td>Enter the patient’s nine-digit Medicaid identification number.</td>
</tr>
<tr>
<td>61</td>
<td>Insured group name</td>
<td>Enter the name and address of the other health insurance.</td>
</tr>
<tr>
<td>62</td>
<td>Insurance group number</td>
<td>Enter the policy number or group number of the other health insurance.</td>
</tr>
<tr>
<td>63</td>
<td>Treatment authorization code</td>
<td>Enter the prior authorization number if one was issued.</td>
</tr>
<tr>
<td>65</td>
<td>Employer name</td>
<td>Enter the name of the patient’s employer if health care might be provided.</td>
</tr>
<tr>
<td>66</td>
<td>Diagnosis/Procedure Code Qualifier</td>
<td>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 = ICD-9-CM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 = ICD-10-CM</td>
</tr>
<tr>
<td>67</td>
<td>Principal diagnosis (DX) code and</td>
<td>Enter the ICD-10-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
|          | present on admission (POA) indicator | **Required:** POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.  
**Refer to:** Subsection 6.4.2.7.3, “Inpatient Hospital Claims” in this section for POA values in the TMHP website.                                                                                                                                                        |
| 67A-67Q  | Secondary DX codes and POA indicator | Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only.  
A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB “141”).  
**Exception:** A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein  
**Note:** ICD-10-CM diagnosis codes entered in 67K–67Q are not required for systematic claims processing.  
**Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.  
**Refer to:** Subsection 6.4.2.7.3, “Inpatient Hospital Claims” in this section for POA values in the TMHP website.                                                                                                                                                      |
| 69       | Admit DX code                       | Enter the ICD-10-CM diagnosis code indicating the cause of admission or include a narrative  
**Note:** The admitting diagnosis is only for inpatient claims.                                                                                                                                                                                                                                                                   |
| 70a-70c  | Patient’s reason DX                 | **Optional:** New block indicating the patient’s reason for visit on unscheduled outpatient claims.                                                                                                                                                                                                                                                                   |
| 71       | Prospective Payment System (PPS) code | **Optional:** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.                                                                                                                                                                                                                     |
| 72a-72c  | External cause of injury (ECI) and POA indication | **Optional:** Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis.  
**Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.  
**Refer to:** Subsection 6.4.2.7.3, “Inpatient Hospital Claims” in this section for POA values in the TMHP website.                                                                                                                                                                      |
<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>the shaded area for inpatient claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer to: Subsection 6.4.2.7.3, “Inpatient Hospital Claims” in this section for POA values in the TMHP website.</td>
</tr>
<tr>
<td>74</td>
<td>Principal procedure code and date</td>
<td>Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.</td>
</tr>
<tr>
<td>74a-74e</td>
<td>Other procedure codes and dates</td>
<td>Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.</td>
</tr>
<tr>
<td>76</td>
<td>Attending provider</td>
<td>Enter the attending provider name and identifiers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NPI number of the attending provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services that required an attending provider are defined as those listed in the ICD-10-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.</td>
</tr>
<tr>
<td>77</td>
<td>Operating</td>
<td>Enter operating provider’s name (last name and first name) and NPI number of the operating provider.</td>
</tr>
<tr>
<td>78-79</td>
<td>Other</td>
<td>Other provider’s name (last name and first name) and NPI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>This block is used to explain special situations such as the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------------</td>
</tr>
</tbody>
</table>
|          |             | • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician.  
|          |             | • If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in Block 39.  
|          |             | • If the services resulted from a family planning provider’s referral, write “family planning referral.”  
|          |             | • If services were provided at another facility, indicate the name and address of the facility where the services were rendered.  
|          |             | • If laboratory work is sent out, the name and address or the provider identifier of the facility where the work was forwarded must be entered in this block  
|          |             | • Request for 110-day rule for a third party insurance. |

| 81A-81D  | Code code (CC) | Optional: Area to capture additional information necessary to adjudicate the claims. required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not support elsewhere on the claim data set. |

### Occurrence Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Auto accident/auto liability insurance involved</td>
<td>Enter the date of auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault.</td>
</tr>
<tr>
<td>02</td>
<td>Auto or other accident/no fault involved</td>
<td>Enter the date of the accident including auto or other where no fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24,50 and 51 to document coordination of benefits with the no-fault insurer.</td>
</tr>
</tbody>
</table>
| 03   | Accident/tort liability | Enter the date of an accident (excluding automobile) resulting from a third part action. This incident may involve a civil court action in an attempt to require payment by the third part other than no-fault liability.  
| 04   | Accident employment-related | Enter the date of an accident that allegedly relates to the patient’s employment and involves compensation or employer liability |
| 05   | Other accident | Enter the date of an accident not described by the above codes  
<p>|      |             | Use this code to report no other casualty related payers have been determined. |
| 06   | Crime victim | Enter the date on which a medical condition resulted |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Last menstrual period</td>
<td>Enter the date of the last menstrual period when the service is maternity-related.</td>
</tr>
<tr>
<td>11</td>
<td>Onset of symptoms</td>
<td>Indicate the date the patient first become aware of the symptoms or illness being treated.</td>
</tr>
<tr>
<td>16</td>
<td>Date of last therapy</td>
<td>Indicate the last day of therapy services for OT, PT, or speech therapy (ST).</td>
</tr>
<tr>
<td>17</td>
<td>Date outpatient OT plan established or last reviewed</td>
<td>Indicate the date a plan was established or last reviewed for occupation therapy.</td>
</tr>
<tr>
<td>24</td>
<td>Date other insurance denied</td>
<td>Enter the date of denial of coverage by TPR.</td>
</tr>
<tr>
<td>25</td>
<td>Date benefits terminated by primary payer</td>
<td>Enter the last date for which benefits are being claimed.</td>
</tr>
<tr>
<td>27</td>
<td>Date home health plan of treatment was established</td>
<td>Enter the date the current plan of treatment was established.</td>
</tr>
<tr>
<td>29</td>
<td>Date outpatient PT plan established or last reviewed</td>
<td>Indicate the date a plan of treatment was established or last reviewed for physical therapy.</td>
</tr>
<tr>
<td>30</td>
<td>Date outpatient speech pathology plan established or last reviewed</td>
<td>Indicate the date a plan of treatment for speech pathology was established or last reviewed.</td>
</tr>
<tr>
<td>35</td>
<td>Date treatment started for PT</td>
<td>Indicate the date services were initiated for physical therapy.</td>
</tr>
<tr>
<td>44</td>
<td>Date treatment started for OT</td>
<td>Indicate when occupational therapy services were initiated.</td>
</tr>
<tr>
<td>45</td>
<td>Date treatment started for speech language pathology (SLP)</td>
<td>Indicate when speech language pathology services were initiated.</td>
</tr>
<tr>
<td>50</td>
<td>Date other insurance paid</td>
<td>Indicate the date the other insurance paid the claim.</td>
</tr>
<tr>
<td>51</td>
<td>Date claim filed with other insurance</td>
<td>Indicate the date the claim was filed to the other insurance.</td>
</tr>
<tr>
<td>52</td>
<td>Date renal dialysis initiated</td>
<td>Indicate the date the renal dialysis is initiated.</td>
</tr>
</tbody>
</table>

**Patient Discharge Status Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Routine discharge</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>02</td>
<td>Discarded to another short-term general hospital for inpatient care</td>
</tr>
<tr>
<td>03</td>
<td>Discharged to SNF</td>
</tr>
<tr>
<td>04</td>
<td>Discharged to ICP</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/transferred to a designated cancer center or children’s hospital</td>
</tr>
<tr>
<td>06</td>
<td>Discharged to care of home health service organization</td>
</tr>
<tr>
<td>07</td>
<td>Left against medical advice</td>
</tr>
<tr>
<td>08</td>
<td>Reserved for national assignment</td>
</tr>
<tr>
<td>09</td>
<td>Admitted as an inpatient to the hospital (only for use on Medicare outpatient hospital claims)</td>
</tr>
<tr>
<td>20</td>
<td>Expired or did not recover</td>
</tr>
<tr>
<td>30</td>
<td>Still patient (To be used on when the client has been in the facility for 30 consecutive days if payment is based on (DRG)</td>
</tr>
<tr>
<td>40</td>
<td>Expired at home (hospice use only)</td>
</tr>
<tr>
<td>41</td>
<td>Expired in a medical facility (hospice use only)</td>
</tr>
<tr>
<td>42</td>
<td>Expired – place unknown (hospice use only)</td>
</tr>
<tr>
<td>43</td>
<td>Discharged/transferred to a federal hospital (such as a Veteran’s Administration (VA) hospital or VA skilled nursing facility)</td>
</tr>
<tr>
<td>50</td>
<td>Hospice - Home</td>
</tr>
<tr>
<td>51</td>
<td>Hospice – Medical facility (includes patient who is discharged from acute hospital care but remains at the same hospital under hospice care)</td>
</tr>
<tr>
<td>61</td>
<td>Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed</td>
</tr>
<tr>
<td>62</td>
<td>Discharged/transferred to Inpatient Rehabilitation Facility (IRF), including rehabilitation distinct part units of a hospital</td>
</tr>
<tr>
<td>63</td>
<td>Discharged/transferred to a Medicare Certified long-term care hospital (LTCH)</td>
</tr>
<tr>
<td>64</td>
<td>Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Do not use when a patient is transferred to an inpatient psychiatric unit of a federal (VA) hospital. See Patient status Code 43 above.</td>
</tr>
<tr>
<td>66</td>
<td>Discharged/transferred to critical access hospital (CAH)</td>
</tr>
<tr>
<td>71</td>
<td>Discharged to another institution of outpatient services</td>
</tr>
<tr>
<td>72</td>
<td>Discharged to another institution</td>
</tr>
</tbody>
</table>

**Coordination of Benefits**

When a STAR+PLUS member has other insurance benefits, the provider must bill the other insurance carrier prior to billing Cigna-HealthSpring. Within ninety-five (95) days of receipt of the primary payer's explanation of payment statement, the provider must file the claim with Cigna-HealthSpring. If the primary payer has not responded to, or has delayed payment on, a provider’s claim for more than 110 days from the date the claim was filed, Cigna-HealthSpring will consider the claim for reimbursement. Providers must supply the following information to Cigna-HealthSpring within 365 days of the date of service:
- Name and address of the primary payer
- Date the primary payer was billed
- Statement signed and dated by the provider indicating at disposition has not been received from the primary payer within 110 days of the date the claim was filed

Providers should submit the claim to Medicaid as soon as disposition is received from the other insurance company or once the 110 days has elapsed to ensure the payment deadlines are not missed.

**Prior Authorization**

**Unit Rate Services**
Nursing Facility will continue to complete and submit Minimum Data Set (MDS) and Long Term Care Medical Information (LTCMI) and submit to TMHP. Cigna-HealthSpring STAR+PLUS will not do reassessments for NF Unit Rate services, though they may bring to the Nursing Facility attention items for consideration.

**Add-on Services**
STAR+PLUS MCOs will be responsible for authorizing claims for Nursing Facility Add-on Services. For example: CPWC, augmentative communication devices, emergency dental, etc. Refer to the Cigna-HealthSpring STAR+PLUS Provider manual located in our website [http://starplus.cignahealthspring.com/](http://starplus.cignahealthspring.com/) for authorization process.

**Acute Care Services**
For members who have only Medicaid, STAR+PLUS MCOs will be responsible for authorizing claims for Acute Care services, such as an acute facility admission, Nursing Facility in-house providers delivering Rehabilitative add-on services (including assessments), other services out of the scope of the Unit Rate Services and the Add-on Services. For authorization and claims information process, the Nursing Facility must refer to the STAR+PLUS provider manual located in our website [http://starplus.cignahealthspring.com/](http://starplus.cignahealthspring.com/). The Nursing Facility Provider can also contact Provider Services department at 1-877-653-0331.

**Claims Payment**
Cigna-HealthSpring processes Unit Rate Clean Claims, as defined by the Cigna-HealthSpring participating provider agreement, within ten (10) days of receipt of the claim. Electronic pharmacy claim by Cigna-HealthSpring’s pharmacy vendor within eighteen (18) days of receipt. Within thirty (30) days of receipt for Add-on Services claims. Cigna-HealthSpring nursing facility and therapy providers are reimbursed in accordance with DADS authorized rates. Claims submitted for NF Rate and Medicare coinsurance will continue to be authorized by DADS. Cigna-HealthSpring will not reassess or authorize services resulting from the MDS and covered under the NF Unit Rate. Cigna-HealthSpring providers are reimbursed in accordance with their Cigna-HealthSpring participating provider agreements for add-on services. Cigna-HealthSpring will pay Provider interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not adjudicated within ten (10) days. There should be no need for special settlements except for advance draws by providers against future payments, unless agreed to by both the MCO and the provider by contract. The intent of this provision is to preclude MCOs from settling with
providers for service rendered or for interest payments due to inaccurate or untimely processing of claims by the MCO or its Subcontracted Claims Processor. The MCO should inform providers that the HHSC/MCO Contract allows for the resolution of disputes through binding arbitration or litigation according to the MCO’s provider contracts.

**Internal Claims Auditing**
The MCO must maintain appropriate levels of claims auditing staff to quickly identify processing errors and trends. The MCO’s claims audit procedures must comply with accepted industry practices, processes and standards.

The MCO must provide adequate training and supervision to audit staff and claim processors. The claims audit reports should be reviewed with MCO management to ensure that claims processing and management systems are adjusted as needed for continuous quality improvement. The claims auditing function should report to the highest level of claims operations, or to a higher executive management position.

All MCO claims data, processing, performance, and functions are subject to audit by HHSC, HHSC’s designated agent, or federal or state audit entities.

**Electronic Funds Transfer**
Cigna-HealthSpring has contracted with Change Healthcare (formerly Emdeon) to deliver electronic funds transfer (EFT) services.

If you are an existing EFT member with Change Healthcare (formerly Emdeon) and wish to add Cigna-HealthSpring to your service, please call 1-866-506-2830 and select Option 1 to speak with an Enrollment Representative.

If you would like to learn more or sign up for EFT, please visit Change Healthcare’s (formerly Emdeon) ePayment Web site at [http://www.emdeonepayment.com](http://www.emdeonepayment.com) where you will be able to:

- Learn more about the EFT service offering
- Check out Change Healthcare’s (formerly Emdeon) Payer List to see all available EFT-enabled payers
- Obtain the EFT enrollment forms
- Register for Online EFT Enrollment and Account Management Access

**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 (formerly Emdeon) 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 (formerly Emdeon) ERA Group:
  - Email: Batchenrollment@changehealthcare.com
Fax: 1-615-885-3713

Any questions related to ERA Enrollment or the ERA process in general, please call Change Healthcare (formerly Emdeon) ePayment Solutions at 1-866-506-2830 for assistance.

NOTE: ERA enrollment for all Cigna-HealthSpring health plans must be enrolled under Cigna-HealthSpring Payer ID “52192”.

Claim Status and Resolution of Claims Issues
Provider Services can assist providers with questions concerning eligibility, benefits, claims and claims status. To check claims status, providers can call the Provider Services Department at 1-877-653-0331 or access the provider portal at https://starplus.hsconnectonline.com. If a claim needs to be reprocessed for any reason, Provider Services will coordinate reprocessing with the Claims Department.

The Provider can also contact his/her Nursing Facility Representative for additional assistance. The Nursing Facility Representative’s responsibilities include: maintaining the provider network, ensuring a sufficient number of providers are available in each county to serve the health care needs of members enrolled in Cigna-HealthSpring’s STAR+PLUS Program; respond to any inquiries related to contracting and credentialing requirements and serve as the primary liaison with participating providers to resolve any operational challenges between the Provider and Cigna-HealthSpring. Providers can contact Provider Services Department at 1-877-653-0331 for assistance eligibility, claims status, applied income changes, authorization status and Member concerns. For all other questions you can contact Nursing Facility Provider Representative in your Service Delivery Area (SDA):

- Jessica Lerma
  - Covers Hidalgo SDA and MRSA SDA
  - Email to Jessica.Lerma@healthspring.com
  - Call to (214) 604-7448

- Noe Salazar
  - Covers Tarrant SDA and MRSA SDA
  - Email to Noe.Salazar@healthspring.com
  - Call to (469) 404–7673.

Overpayments
An overpayment can be identified by the provider or Cigna-HealthSpring. If the provider identifies the overpayment, they can either submit a refund check all with an explanation of refund and/or Explanation of Payment (EOP) to Cigna-HealthSpring or they can call Provider Services at 877-653-0331 and approve a recoupment from any future payments to the provider. If Cigna-HealthSpring identifies the overpayment, a recovery letter will be sent to the provider within 30 days after identifying the overpayment. The letter will be specific and include the basis for the recovery, and the provider has 30 days to submit a refund check or appeal the refund request. If the provider doesn’t respond within 30 days from the date of the recovery letter, then recoupment will begin on any future payments. Refund checks, along with explanation of refund, can be sent to:
Claims Appeals
An 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. When submitting claims please follow the guidelines listed below:

- Providers must request claim appeals within 120 days from the date of remittance of the Explanation of Payment (EOP).
- Providers may fax written claims appeals to 1-877-809-0783 or mail them to:
  Cigna-HealthSpring
  Appeals and Complaints Department
  P.O. Box 211088
  Bedford, Texas 76095
- In the event that Cigna-HealthSpring requires additional information to process an appeal, the provider must return requested information within twenty-one (21) days from the date of Cigna-HealthSpring's request. If the requested information is not received within this time, the case will be closed. A claim appeal form is located on our provider website, as well as Appendices of this provider manual, that list the information that we would like to receive in order to process your appeal correctly. For example:
  - Claim Number
  - Date of service
  - Member Name
  - Medicaid ID #
  - The reason or basis for the appeal

An acknowledgement letter is sent within five (5) business days of receiving a provider’s written claim appeal. Provider claim appeals are resolved within thirty (30) days of receipt of the claim appeal. Cigna-HealthSpring sends written notification of the resolution to the provider.
Note: A corrected claim is not an appeal.

Payment Disputes
A payment dispute is a written communication (i.e. a letter) from the Provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records. This form may also be used for a nursing facility RUG level change. To check claims status, providers can call the Provider Services Department at 1-877-653-0331.

The documentation must also include a description of the reason for the request:
- Indicate “Payment dispute of (original claim number)”
- Include a copy of the original Explanation of Payment
• Unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim.

Reasons of when to use the payment dispute form:
• Denial for “timely filing”, but provider has proof of timely
• Denial for “no authorization on file”, but provider has authorization listed
• Denial for “benefit not covered”, but per TMHP it is payable
• Denial for “no coverage”, but Member was active during the Date of Service (DOS)
• Provider not being paid at correct reimbursement rate, paid incorrectly
• Denial for incorrect modifier, CPT code, National Drug Code (NDC) number, NPI/TIN/TPI, Place of Service (POS), Date of Service (DOS), Type of Bill (TOB), Diagnosis (DX) code, etc. and denied incorrectly
• Denial for “no active provider contract” and provider does have an active contract listed
• Denial for insufficient units, per authorization on file there’s units available, or there’s no units available due to error on our end
• Denial for “bundled services”, per NCCI (National Correct Coding Initiative) edits they should not be bundled
• Denial for incorrect payment
• Denial for physician assist (PA), but per guidelines it should be allowed and payable
• Denied for “acute services need to be billed to primary insurance”, per Member’s eligibility might be covered under their LTSS benefits
• Denial with no reason
• Denial for “benefit not covered out of network”, but Member was at the hospital for inpatient/outpatient stay and a NON-PAR doctor saw the Member while hospitalized and provider billed with correct POS, TOB and CPT codes
• Denial for “no Member match” but the Member was active for DOS, and DOB, ID and name all match the original submission
• Denial for “service included within the visit rate,” but paid nothing on the claim and there is no duplicate listed

The Payment Dispute Form can be found on our website http://starplus.cignahealthspring.com. Providers can fax the Payment Dispute Form to 1-877-809-0783, e-mail to Claims_MMP_Medicaid@HealthSpring.com or mail to:

Attention: Cigna-HealthSpring Payment Dispute Unit
P.O. BOX 211088
Bedford, TX 76095

**Corrected Claims Process**
You can submit a corrected claim in electronic format.

When submitting a corrected claim on a UB 04, the claim must clearly be marked as “Corrected Claim” along with the third digit of Type of Bill indicated as Frequency code 7.
Corrected claims must be sent within 120 days of initial claim disposition. Failure to mark the claim as Corrected could result in a duplicate claim and be denied for exceeding the 365 days timely-filing deadline.

**Balance Billing**
Participating Cigna-HealthSpring providers are prohibited from balance billing STAR+PLUS members including, but not limited to, situations involving non-payment by Cigna-HealthSpring, insolvency of Cigna-HealthSpring, or Cigna-HealthSpring’s breach of its agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against members or persons, other than Cigna-HealthSpring, acting on behalf of members for covered services provided pursuant to the Cigna-HealthSpring participating provider agreement. The provider is not, however, prohibited from collecting copayments, co-insurances or deductibles for non-covered services in accordance with the terms of the applicable member’s benefit plan.

In the event that a provider refers a member to a non-participating provider without prior authorization from Cigna-HealthSpring, if required, or provides non-covered services to a member, the provider must inform the member in advance, in writing: (i) of the service(s) to be provided; (ii) that Cigna-HealthSpring will not pay for or be liable for said service(s); and (iii) that the member will be financially liable for such services. In the event the provider does not comply with the requirements of this section, the provider shall be required to hold the member harmless as described above.

Cigna-HealthSpring will initiate and maintain any action necessary to stop a network provider or employee, agent, assign, trustee or successor-in-interest of network provider from maintaining an action against HHSC, an HHSC agency or any member to collect payment from HHSC, an HHSC agency or any member above an allowable copayment or deductible, excluding payment services not covered by STAR+PLUS.

If a Cigna-HealthSpring member decides to go to an out-of-network provider or chooses to get services that have not been authorized or are not a covered benefit, the member must document his/her choice by signing the member Acknowledgement Statement provided in Appendices of this manual. Once the member signs a member acknowledgment statement, the provider may bill the member for any service that is not a benefit under Cigna-HealthSpring or the Texas Medicaid Program.

**Private Pay Agreement**
If a member elects to be a "private pay" patient, the provider must advise member at the time of service that he/she is responsible for paying for all services received. The provider should require the member to sign the Private Pay Form provided in Appendices of this manual. This documents that the member has been properly notified of the private pay status. Providers are allowed to bill members as private pay patients if retroactive Medicaid eligibility is not granted. If the member becomes eligible retroactively, the member must notify the provider of the change in status. The provider must refund money paid by the member and file claims to the appropriate payer for all services rendered. Ultimately, the provider is responsible for filing Medicaid claims in a timely manner.
**Claim Filing Tips**

- If two identical claims are received for the same service on the same date for the same member, one of the claims will be denied as an ‘exact’ duplicate; unless noted as a corrected claim. Please see section “Corrected Claims Process.”
- The correct Cigna-HealthSpring member ID number must be on the claim.
- Use only valid procedure codes by consulting the current CPT® book, HCPCS Manual and/or the LTSS HCPCS Codes and STAR+PLUS Modifiers Matrix. CPT® books are available at most bookstores or they can be ordered by contacting the American Medical Association at 1-312-464-5000 or toll free at 1-800-621-8335. ICD-10-CM diagnosis code books can be found at most bookstores or by contacting the American Hospital Association at 1-312-422-3000 or toll free at 1-800-424-4301.
- When using a modifier, whether from Appendices of the CPT manual or as required by TMHP manual, place it immediately following the 5-digit procedure code. Do not insert a space or a dash.
- Claims should be submitted for one member and one provider per claim form.
- Providers should list only one authorization number per claim form.
- Providers need to bill the required National Drug Code (NDC) for certain HCPCS procedure codes. Reference the following website for the NDC/HCPCS crosswalk and additional information: [www.dmepdac.com/crosswalk/index.html](http://www.dmepdac.com/crosswalk/index.html).
- Providers billing on a UB-04 should only bill with a patient status 30 (box 17) when the member is inpatient.
**Sample of Explanation of Payment (EOP)**

2900 N. Loop West
Ste. 1300
Houston, TX 77092

**Forwarding Service Requested**

11637 0.5486 AT 0.381 3-DIGIT 785

Smith, John
PO BOX 4587
Mission, TX 78573-4587

---

**Explanation of Payment**

<table>
<thead>
<tr>
<th>Medicaid ID:</th>
<th>##########</th>
<th>Plan:</th>
<th>STAR+PLUS Hidalgo</th>
<th>Provider Acct No:</th>
<th>458741</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name:</td>
<td>Jane Doe</td>
<td>Claim Number:</td>
<td>587654E47896</td>
<td>Provider Name:</td>
<td>Smith, John</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>From Date of Service</th>
<th>To Date of Service</th>
<th>Service Code</th>
<th>Billed Amount</th>
<th>Allowed Amount</th>
<th>Copay Coinsurance</th>
<th>Deductible</th>
<th>Adjustment</th>
<th>Interest</th>
<th>Payment</th>
<th>Reason Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/06/2013</td>
<td>09/06/2013</td>
<td>99213</td>
<td>165.00</td>
<td>33.27</td>
<td>0.00</td>
<td>131.73</td>
<td>0.00</td>
<td>33.27</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Claim Totals:**

|             |             |             | 165.00 | 33.27 | 0.00 | 131.73 | 0.00 | 33.27 |

**Vendor Totals:**

|         |         |             | 165.00 | 33.27 | 0.00 | 131.73 | 0.00 | 33.27 |

**Remark Code Explanation**

901 $0.00 Beginning balance from recovery amounts
902 $0.00 Recovery amounts applied to this check
903 $0.00 Check(s) received from provider for this check period
904 $0.00 Amount Written Off
905 $0.00 Outstanding balance not yet applied

*** Claims appeals must be submitted in writing within 120 calendar days from the date of your Remittance or Explanation of Payment (EOP).

---

**Cigna-HealthSpring STAR+PLUS**

2900 N. Loop West Ste. 1300
Houston, TX 77092

**PAY Thirty Three & 27/100 Dollars**

TO THE  Smith, John
ORDER OF  PO Box 4587
Mission, TX 78573-4587

Amegy Bank
San Antonio, TX 78229

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**VOID**
Provider Responsibilities
Cigna-HealthSpring recognizes and values each provider's immeasurable contributions to the STAR+PLUS program. Without a dedicated team of health care providers, Cigna-HealthSpring could not successfully deliver on its goal of improving access to care, quality of care, and member satisfaction. To ensure providers have access to all resources and tools needed to support Cigna-HealthSpring members, Cigna-HealthSpring employs a Provider Services team to assist providers when daily operations do not go as planned. The Provider Services team is available to assist providers with general questions and/or schedule educational in-services with the provider’s office if needed. Providers can reach the Cigna-HealthSpring Provider Services Department by calling 1-877-653-0331. In order to ensure a successful partnership with Cigna-HealthSpring, providers should familiarize themselves with all sections of the Cigna-HealthSpring provider manual, including the following Cigna-HealthSpring important participation requirements.

Communication Among Providers
It is essential that Cigna-HealthSpring providers communicate with each other to ensure appropriate and timely member access to care. When referring members for care, PCPs should provide physical health and/or Behavioral Health providers with all relevant clinical information regarding the member’s care, including the results of any diagnostic tests and laboratory services. Specialty physician providers should forward to the member's PCP a summary of all visits, clinical findings, and treatment plans. PCPs should document this information appropriately in the member's medical record.

Provider Access and Availability Standards
Cigna-HealthSpring requires that all Providers maintain appropriate after-hours accessibility and appointment availability for all of our Members. Standards are measured from the date the Member arrives for the appointment or calls to schedule one, whichever occurs first. The National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations, has rigorous measures for after-hours accessibility and appointment availability. Cigna-HealthSpring follows NCQA guidelines for the after-hours accessibility and appointment availability. Providers can reach the Cigna-HealthSpring Provider Services Department by calling 1-877-653-0331 or to be transferred to their representative of the service delivery area.

After Hours Accessibility
Cigna-HealthSpring PCPs and Specialty Care Providers (SCP) are required to maintain after-hours call coverage to ensure members have access to care twenty-four (24) hours per day, seven (7) days per week. Recorded messages must include English and Spanish option and other language requirements of the provider's patient population. The following are acceptable and unacceptable phone arrangements for contacting PCPs or SCPs after normal business hours:

Acceptable After-hours Coverage:
1. Office telephone is answered after-hours by an answering service, which meets the language requirements of the provider's patient population, and can contact the provider or another designated provider. All calls related to patient care answered by an answering service must be returned within thirty (30) minutes.
2. Office telephone is answered after normal business hours by a recording, which meets the language requirements of the provider's patient population and directs the member to call another number to reach the provider or another provider designated by the PCP or SCP. Someone must be available to answer the designated provider’s telephone. Another recording is not acceptable.

3. Office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, SCP or another designated provider. All calls related to patient care must be returned the call within thirty (30) minutes.

**Unacceptable After-hours Coverage:**
1. Office telephone is answered only during office hours.
2. Office telephone is answered after-hours by a recording that tells members to leave a message.
3. Office telephone is answered after-hours by a recording that directs members to go to an emergency room for all services needed.
4. Patient care-related calls are not returned within thirty (30) minutes.
5. No answer after 10 rings when calling after hours.
6. Recorded message did not include both English and Spanish language options.
7. Recorded message did NOT provide a way to reach a live party after business hours.
8. No answer after following automated message prompts to reach a live party.
9. The patient was not able to speak with a medical provider within 30 minutes.

**Appointment Accessibility**
All Cigna-HealthSpring providers are required to offer timely appointments to members as indicated in the following Appointment Availability Standards:

<table>
<thead>
<tr>
<th>Type of Appointment or Service</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Upon member presentation at the service delivery site, including at non-network and out-of-area facilities.</td>
</tr>
<tr>
<td>Urgent care appointments</td>
<td>Within twenty-four (24) hours for primary, specialty, and pediatrics. Triage nurse or Provider would assess. Behavioral health within forty-eight (48) assessed by a Provider or a triage nurse.</td>
</tr>
<tr>
<td>Routine primary care</td>
<td>Within fourteen (14) days for non-urgent, symptomatic condition.</td>
</tr>
<tr>
<td>Routine specialty care referrals</td>
<td>No later than 30 days after request for non-urgent, symptomatic condition.</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>Initial outpatient behavioral health visits must be provided within 10 days. No later than 30 days after request for non-urgent, symptomatic condition.</td>
</tr>
<tr>
<td>Adult preventive health physicals and well visits for members over age 21</td>
<td>Within ninety (90) days.</td>
</tr>
<tr>
<td>Pediatric preventive health physicals and well child checkups for</td>
<td>As soon as possible for members who are due or overdue for services in accordance the Texas Health Steps</td>
</tr>
<tr>
<td>Type of Appointment or Service</td>
<td>Timeframe</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>members under age 21, including Texas Health Steps services</td>
<td>Periodicity Schedule and the American Academy of Pediatrics guidelines, but in no case later than fourteen (14) days of enrollment for newborns and no later than ninety (90) days of new enrollment for all others. Effective September 1, 2010, the Texas Health Steps annual medical checkup for an existing member 36 months of age and older is due on the child’s birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child’s birthday.</td>
</tr>
<tr>
<td>Prenatal care/ first visit</td>
<td>Within fourteen (14) days For high-risk pregnancies or new members in the third trimester, appointments should be offered no later than five (5) days or immediately if an emergency exists.</td>
</tr>
<tr>
<td>Office waiting time</td>
<td>Within thirty (30) minutes of the scheduled appointment time.</td>
</tr>
</tbody>
</table>

**Demographic Changes**

Cigna-HealthSpring providers should review the Cigna-HealthSpring Provider Directory, both printed and online, to ensure Cigna-HealthSpring maintains the most updated demographic information, i.e., physical address, claims payment remit address, phone and facsimile numbers, etc. Providers must notify Cigna-HealthSpring, HHSC’s and Department of Aging and Disability Services (DADS) administrative services contractor in advance of any change in demographic information, preferably thirty (30) days prior to the effective date of the change. Cigna-HealthSpring will also, on a quarterly basis, contact you to verify the demographic information we have on file is accurate. By providing this information and responding in a timely manner, you will ensure that your practice is listed correctly in the Provider Directory.

The following types of demographic changes should be faxed to 1-877-440-7260 or emailed to ProviderDataValidation@healthspring.com:

- Tax identification number
- Office address
- Billing address
- Telephone number
- Changes in practice limits or office hours
- Specialty
- The departure of or addition of a new physician to an existing practice

**Advanced Medical Directives**

The Federal Patient Self-Determination Act ensures the patient’s right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by the
Centers for Medicare and Medicaid Services (CMS), HEDIS® requirements, and Cigna-HealthSpring policies and procedures, participating Cigna-HealthSpring providers are required to have a process that complies with the Patient Self Determination Act. Cigna-HealthSpring monitors provider compliance with this requirement by conducting periodic medical record reviews confirming the presence of required documentation.

A Cigna-HealthSpring member may inform his/her providers that he/she has executed, changed, or revoked an advance directive. At the time services are provided, providers should ask members to provide a copy of their advance directives. If a provider cannot, as a matter of conscience, fulfill a member’s written advance directive, he/she must advise the member and the Cigna-HealthSpring Service Coordinator. The Service Coordinator will work with the provider to arrange for a transfer of care.

Participating providers may not condition the provision of care or otherwise discriminate against a member based on whether the member executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the provider’s right under state law to refuse to comply with an advance directive as a matter of conscience.

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

Cigna-HealthSpring works with Texas Department of Family and Protective Services (TDFPS) to advance directives including: to ensure that any pediatric members in custody or under the supervision of TDFPS receive needed services. The needs of this population are special in that children will transition in and out of care more frequently than the general population.

A member’s right to self-determination in making health care decisions; the Advance Directives Act, Chapter 166, Texas Health and Safety Code, includes:

1. A member’s right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition
2. A member’s right to make written and non-written out-of-hospital do-not-resuscitate (DNR) orders
3. A member’s right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the member’s behalf if the member becomes incompetent
4. Chapter 137, Texas Civil Practice and Remedies Code, which includes a member’s right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment

In order to meet regulatory goals regarding quality of care the provider will document advance care planning when it occurs. Advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end of life care. Evidence of advance care planning must include one of the following:

- The presence of an advance care plan in the medical record
- Documentation of an advance care planning discussion with the provider and the date when it was discussed. The documentation of discussion must be noted during the measurement year
• Notation that the member previously executed an advance care plan

Cigna-HealthSpring requires that providers:

• Coordinate with TDFPS and foster parents for the care of a child who is receiving services from, or has been placed in the conservatorship of TDFPS, and respond to requests from TDFPS
• Provide medical records to TDFPS
• Provide periodic written updates on treatment status of members, as required by TDFPS
• Schedule appointments for medical and behavioral health services within fourteen (14) days unless requested earlier by TDFPS
• Train staff on how to recognize and report abuse, neglect, and/or exploitation
• Refer suspected abuse, neglect, and/or exploitation to TDFPS by calling toll free at 1-800-252-5400 or by using the TDFPS secure website at http://www.txabusehotline.org.

Cigna-HealthSpring must continue to provide all covered services to a member receiving services from, or in the protective custody of TDFPS until the member is placed into foster care or disenrolls from Cigna-HealthSpring due to loss of eligibility. If a provider is caring for a member in custody or under supervision of TDFPS, they are encouraged to contact the member’s Service Coordinator for any care coordination needs.

Coordination With Governmental Entities
Cigna-HealthSpring works with the Texas Department of Aging and Disability Services - Consumer Rights and Services, the Department of Family and Protective Services - Adult Protective Services and other governmental entities to assure that members safely receive needed care and services. Providers will cooperate and coordinate with all interested governmental agencies to further this goal.

Termination of Provider Contracts
A provider may terminate from the Cigna-HealthSpring network according to the Cigna-HealthSpring participating provider agreement which details the written notification timeframes and other termination provisions. If a provider agreement terminates, Cigna-HealthSpring will notify affected members in writing at least fifteen (15) days prior to the effective date of the termination. Affected members include all members in a PCP’s panel and all members receiving ongoing care from the terminated provider, where ongoing care is defined as two (2) or more visits for home-based or office-based care in the past twelve (12) months.

In the event that a member is receiving covered services at the time a provider agreement is terminated, the provider must continue to provide covered services until the treatment is completed. Once treatment is complete, Cigna-HealthSpring will coordinate the transition of care to another participating Cigna-HealthSpring provider.

Applied Income
Applied income is the portion of the earned and unearned income of the STAR+PLUS Member, or if applicable the Member and the Member’s spouse, that is paid under the Medicaid program to an institution or long-term care facility in which the Member resides.
The Member's monthly applied income amount will be transmitted to the MCOs by TMHP in the Service Authorization System (SAS) interface file. The Member's applied income amount should be used in the pricing of the Nursing Facility Unit Rate, reducing the amount paid by Medicaid by the amount of applied income for the dates of service.

If a payment plan appears incorrect, the facility administrator should contact HHSC to correct the plan. Even if a recipient's income increases, the administrator must not collect an increased payment until the plan is changed. The administrator should not collect an increased payment in anticipation of a payment plan increase.

If an admitted recipient does not have a payment plan, the administrator should contact the local worker for help in determining how much applied income is owed. If the forthcoming forms indicate a lesser payment, the administrator should refund the excess immediately and notify the worker.

Facilities that collect payments (part applied income, part Medicaid) in excess of the vendor rate are in violation of HHSC regulations and of Public Law 95-142 which makes "solicitation of supplementation" a felony.

Regional HHSC staff must report any violations. If an investigation shows that the facility has violated this standard, a recommendation for withholding vendor payments, contract termination, referral to the courts, or other contract action may be made.

The nursing facility must refund the recipient's prorated applied income money when the recipient has paid in advance for the full month and is discharged from the facility any time during the month. The facility must make the refund within 30 calendar days from and including the date of discharge, even when vendor payment has not been received from HHSC. No later than three business days after the effective date of this Agreement, the MCO will provide the name and contact information of a Service Coordinator or other designated representative who will assist with the collection of applied income from members. The MCO must notify the Provider within ten days of any change to the assigned Service Coordinator or representative.

The Provider must make reasonable efforts to collect applied income, document those efforts, and notify the Service Coordinator or the MCO's designated representative when it has made two unsuccessful attempts to collect applied income in a month. This provision in no way subrogates the Provider’s existing regulatory and licensing responsibilities related to the collection of applied income, including the requirements of 40 TAC § 19.2316.

Provider Marketing Guidelines
The below is a general guideline to assist Cigna HealthSpring Providers who have contracted with STAR+PLUS plans and are accepting FFS patients in determining what marketing and patient outreach activities are permissible under the Health and Human Services (HHS) guidelines. Cigna-HealthSpring prohibit providers from steering, or attempting to steer an undecided potential enrollee toward a specific plan, or limited number of plans, offered either by
the plan sponsor or another sponsor, based on the financial interest of the provider or agent. Providers should remain neutral parties in assisting plans to market to beneficiaries or assisting in enrollment decisions.

The Provider can:

- Mail/call their patient panel to invite patients to general Cigna HealthSpring sponsored educational events to learn about the STAR+PLUS program. This is not a sales/marketing meeting. No sales representative or plan materials can be distributed. Sales representative cards can be provided upon request.
- Mail an affiliation letter one time to patients listing only Cigna HealthSpring.
- Have additional mailings (unlimited) to patients about participation status but must list all participating STAR+PLUS plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior HHS approval and the agreement of all plans listed.
- Notify patients in a letter of a decision to participate in a Cigna HealthSpring sponsored program.
- Utilize a physician/patient newsletter to communicate information to patients on a variety of subjects. This newsletter can have a Cigna HealthSpring corner to advice patients of Cigna HealthSpring information. Provide objective information to patients on specific plan formularies, based on a patient’s medications and health care needs.
- Refer patients to other sources of information, such as the State Health Insurance Assistance programs, Cigna HealthSpring Member Services, Health and Human Services (HHS), or Texas Client Enrollment Services to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Display and distribute in provider offices Cigna HealthSpring marketing materials, excluding application forms. The office must display or offer to display materials for all participating plans.
- Notify patients of a physician’s decision to participate exclusively with Cigna HealthSpring for STAR+PLUS or to close panel if appropriate.
- Record messages on our auto dialer to existing Cigna HealthSpring members as long as the message is not sales related or could be construed as steerage. The script must be reviewed by Cigna HealthSpring Legal/Government programs.
- Have staff dressed in clothing with the Cigna HealthSpring logo.
- Display promotions items with the Cigna HealthSpring logo.
- Allow Cigna HealthSpring to have a room/space in provider offices completely separate from where patients have a prospect of receiving health care, to provide beneficiaries’ access to a Cigna HealthSpring sales representative.

The Provider cannot:

- Quote specific health plan benefits or cost share in patient discussions.
- Urge or steer towards any specific plan or limited set of plans.
- Collect enrollment applications in physician offices or at other functions.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
• Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
• Call members who are disenrolling from the health plan to encourage re enrollment in a health plan.
• Mail notifications of health plan sales meetings to patients.
• Call patients to invite patients to sales and marketing activity of health plan.
• Cannot advertise using Cigna HealthSpring’s name without Cigna HealthSpring’s prior consent and potentially HHS approval depending upon the content of the advertisement.

**Continuing Provider Training**
Cigna-HealthSpring offers continuing education training to all Provider types. Available training materials are presentations, webinars, visual aids, quick reference guides, provider manuals, claims and authorization process and more. For presentation and/or webinar trainings the information is detailed on our website under the Provider Education section. Registration requests need to be emailed to the Provider_Training@healthspring.com. Confirmation and webinar meeting details will be forwarded to the Provider. For more information or if you have questions, please contact our Provider Services Department Monday to Friday, 8 a.m. to 5 p.m. Central Time at 877-653-0331.

**Cultural Competency**
Participating providers shall provide covered services in a culturally competent manner to all Members by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled.

All providers must receive training on Cultural Competency initially and annually thereafter. Please go to the link below to familiarize yourself with Cultural Competence, and to access the on-line training. In order to receive credit for completing the training, you must complete a short set of questions, and attestation at the end of presentation. Visit our website at http://starplus.cignahealthspring.com/ProviderEducation to access the presentation.

**Cigna-HealthSpring Provider Compliance and Waste, Abuse, and Fraud Policy**
Cigna-HealthSpring’s Compliance Program monitors compliance with federal and state laws, including healthcare waste, abuse, and fraud statutes and regulations. The Compliance Program is designed to prevent violations of federal and state laws. In the event violations occur, the Compliance Program promotes early and accurate detection, prompt resolution and disclosure to governmental authorities, when appropriate.

Cigna-HealthSpring expects all contracted providers to be ethical and compliant. Cigna-HealthSpring encourages its own employees, as well as each provider's employees, contractors, and other parties, to report suspected violations of law and policy, without fear of retribution.

**Fraud Information:**
**Reporting Waste, Abuse, or Fraud by a Provider or Client Medicaid Managed Care**

**Do you want to report Waste, Abuse, or Fraud?**
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 their Medicaid.
- Using someone else’s Medicaid.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

**To report waste, abuse or fraud, choose one of the following:**

- Call the OIG Hotline at 1-800-436-6184
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form
- You can report directly to your health plan:
  Cigna-HealthSpring
  Attn: Compliance Department
  9009 Carothers Parkway, Suite B-100
  Franklin, TN 37067
  1-800-230-6138

**To report waste, abuse or fraud, gather as much information as possible.**

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person’s name
  - The person’s date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud

**How to report abuse, neglect, and exploitation (ANE)**

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

*Report to the Department of Family and Protective Services (DADS) if the victim is an adult or child who resides in or receives services from:*

- Nursing facilities;
• Assisted living facilities;
• Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
• Adult day care centers; or
• Licensed adult foster care providers

Contact DADS at 1-800-647-7418.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:
• An adult who is elderly or has a disability, receiving services from:
  o Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS
  o Unlicensed adult foster care provider with three or fewer beds
• An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
  o Local intellectual and developmental disability authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services
  o A person who contracts with a Medicaid managed care organization to provide behavioral health services;
  o A managed care organization;
  o An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
• An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS:
• Call 1-800-252-5400
• Online in non-emergency situations at www.txabusehotline.org

Report to Local Law Enforcement:
• If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting
• It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
• It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
• Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family
member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

**Reporting Abuse**
Provider must make available to all Cigna-HealthSpring members information on how to report abuse, neglect or exploitation. The information must include the following:

- DFPS Internet reporting site and toll free number
  - www.txabusehotline.org
  - 800-252-5400

**Provider Complaint and Appeal Process**
Cigna-HealthSpring is committed to providing excellent service to its participating providers. In the event a provider feels Cigna-HealthSpring is falling short of this goal, he/she should contact the Provider Services Department immediately by calling 1-877-653-0331. Provider Services is available to assist providers with their concerns at any time.

**Definitions Overview**

A **Complaint** means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. As provided by 42 C.F.R. 438.400, possible subjects for complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid member’s rights.

An **Action** means
1. The denial or limited authorization of a requested Medicaid service, including the type or level of service
2. The reduction, suspension, or termination of a previously authorized service
3. The denial in whole or in part of payment for service
4. The failure to provide services in a timely manner
5. The failure of an MCO to act within the timeframes set forth in the Contract and 42 C.F.R 438.408(b)
6. For a resident of a rural area with one MCO, the denial of a Medicaid member’s request to obtain services outside of the network

An **Adverse Determination** is one type of Action.

An **Appeal** is a formal process by which a member or his or her representative requests a review of the MCO’s Action as defined above.

An **Authorized Representative** is any person or entity acting on behalf of the member, from whom Cigna-HealthSpring has received the member’s written consent. A provider may be an authorized representative.
A Provider Claim Appeal is a claim that has been previously adjudicated as a Clean Claim and the provider is appealing the disposition through written notification to Cigna-HealthSpring in accordance with the provider claim appeal process as defined in the Cigna-HealthSpring provider manual.

Provider Complaints to Cigna-HealthSpring
Provider complaints can be filed verbally, in writing or through our provider portal by contacting Cigna-HealthSpring as follows:

- Contact Provider Services Monday to Friday, 8 a.m. to 5 p.m. Central Time at 1-877-653-0331
- Fax written claims appeals to the Cigna-HealthSpring Appeals & Complaints Department at 1-877-809-0783
- Mail them to:
  Cigna-HealthSpring
  Appeals and Complaints Department
  P.O. Box 211088
  Bedford, Texas 76095
- Log into HS Connect to access our Claims portal: https://starplus.hsconnectonline.com

If a provider complaint is received verbally, Cigna-HealthSpring’s Provider Services Representatives collect detailed information about the complaint and route the complaint electronically to the Appeals and Grievances Complaint Department for handling. Within five (5) business days from receipt of a complaint, Cigna-HealthSpring will send an acknowledgement letter to the provider. Cigna-HealthSpring will resolve the complaint within thirty (30) days from the date the complaint was received by Cigna-HealthSpring.

Provider Second Level of Appeal
If your appeal is based on medical necessity and you disagree with this decision, you have the option to request a second level appeal. Second Level Appeals are reviewed by a physician contracted by Cigna-HealthSpring to conduct reviews wherein we have not changed our decision. This physician is not a Cigna-HealthSpring STAR+PLUS Network Provider and was not involved with the original decision to deny this service.

To request your second level appeal you must submit a written request to Cigna-HealthSpring within thirty 30-calendar days from the date of the first level appeal decision letter. The review will be completed within fifteen (15) business day from date of receipt of the request. If this appeal involves emergency care of a continued stay review, Cigna-HealthSpring will complete its’ review within one (1) business day from the date that your request is received. If Cigna-HealthSpring’s adverse determination is upheld after the second level appeal, you will have exhausted your appeal process with Cigna-HealthSpring. If you wish to pursue your complaint with the Texas Health and Human Services Commission, you may contact them as follows:
Quality Management

Overview
The Quality Improvement (QI) Program provides a systematic process and infrastructure to monitor and improve quality of care and service delivered within the Cigna-HealthSpring network. The Cigna-HealthSpring QI Program is based upon principles that emphasize:

1. Services that are:
   a) Clinically-driven, cost-effective, and outcome-oriented
   b) Culturally-informed, sensitive, and responsive
   c) Delivered in accordance with guidelines and criteria that are based on professional standards and evidence-based practices, and are adapted to account for regional, rural, and urban differences
2. The goal of enabling members to live in the least restrictive, most integrated community setting appropriate to meet their health care needs
3. An environment of quality of care and service within Cigna-HealthSpring and the provider network
4. Member safety as an overriding consideration in decision-making

QI Department Functions
Cigna-HealthSpring is committed to providing access to quality health care through continuous study, implementation, and improvement. QI assumes no permanent threshold for good performance. As such Cigna-HealthSpring members should expect a comprehensive, therapeutic health care delivery system that is always evolving and improving. Cigna-HealthSpring's QI Department accomplishes this by integrating, analyzing, and reporting data from across the health plan as well as from other data sources. The QI Department prioritizes quality initiatives based on health plan relevance. Then, the QI Department works with internal departments to manage resources effectively, maximizing member health outcomes.
Providers, who have questions about Cigna-HealthSpring’s QI Program, would like a QI Program description and list continuously evolving goals, and goals, or a list of QI Program activities can contact Cigna-HealthSpring’s QI Department at:

Cigna-HealthSpring
Medicaid STAR+PLUS
Attn: Quality Improvement Department
2208 Highway 121, Suite 210
Bedford, TX 76021

Quality Improvement Committee (QIC)
The Medicaid Quality Improvement Committee (QIC) is responsible for the overall design and implementation of Cigna-HealthSpring’s QI Program, as well as for the oversight of QI activities carried out by other committees. The QIC reports to the Corporate Quality Improvement Committee which in turn reports to the Board of Directors. The QIC ensures that all QI tasks and functions include member and provider involvement and that they are conducted in compliance with all applicable regulatory and accreditation requirements.

Clinical Practice Guidelines
Cigna-HealthSpring’s practice guidelines are based on evidence-based, clinical findings. These practice guidelines are reviewed and updated annually by the Provider Advisory Committee (PAC.) New guidelines are added to meet member needs and changes in membership. The clinical practice guidelines, which are available on Cigna-HealthSpring's website, http://starplus.cignahealthspring.com, are based on resources such as:

<table>
<thead>
<tr>
<th>Resource</th>
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<tr>
<td>American Heart Association/American College of Cardiology</td>
<td><a href="http://www.americanheart.org">http://www.americanheart.org</a> <a href="http://www.acc.org">http://www.acc.org</a></td>
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<td>American Medical Association</td>
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<tr>
<td>American Diabetes Association</td>
<td><a href="http://www.professional.diabetes.org">http://www.professional.diabetes.org</a></td>
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<tr>
<td>Global Initiative for Chronic Obstructive Lung Disease</td>
<td><a href="http://www.goldcopd.com">http://www.goldcopd.com</a></td>
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<tr>
<td>American Academy of Pediatrics</td>
<td><a href="http://www.aap.org">http://www.aap.org</a></td>
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<td>National Institute for Health And Clinical Excellence (NICE)</td>
<td><a href="http://www.nice.org">http://www.nice.org</a></td>
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<tr>
<td>American Academy of Family Physicians</td>
<td><a href="http://www.aafp.org">http://www.aafp.org</a></td>
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<tr>
<td>U.S. Preventive Services Task Force</td>
<td><a href="http://www.uspreventiveservicestaskforce.org">http://www.uspreventiveservicestaskforce.org</a></td>
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Healthcare Plan Effectiveness Data and Information Set (HEDIS®)
Healthcare Plan Effectiveness Data and Information Set (HEDIS®) is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters)
and medical record review data. HEDIS measurements related to STAR+PLUS include measures such as well-child visits, immunizations, appropriate use of asthma medications, comprehensive diabetes care, and controlling high blood pressure.

Cigna-HealthSpring's HEDIS measures are reported annually and represent a mandated activity for STAR+PLUS MCOs. Each spring, Cigna-HealthSpring representatives are required to collect copies of medical records from providers to establish HEDIS scores. Selected provider offices will be contacted and requested to assist in these medical record collections. All records are handled in accordance with Cigna-HealthSpring’s privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule (see 45 CFR 164.501 and 506). Cigna-HealthSpring HEDIS results are available upon request. To request information regarding those results, contact our Quality Improvement Department by mail at:

Cigna-HealthSpring
Medicaid STAR+PLUS
Attn: Quality Improvement Department
2208 Highway 121, Suite 210
Bedford, TX 76021

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

On-Site Assessments
Cigna-HealthSpring conducts on-site provider assessments in response to a member complaint to assess the quality of care and services provided. During an on-site visit, Cigna-HealthSpring may assess the following items:

- Physical appearance and accessibility
- Member safety and risk management
- Medical records organization, maintenance and storage
- Security of Information

Depending on the provider type or nature of the complaint, either a provider network representative or nurse will conduct the site review. Each section of the Site Evaluation Form addresses a review topic with questions to be answered “YES”, “NO”, or “N/A” (not applicable). Each answer is scored, and scores are added to generate an overall score for the site. Results of the site review shall be reported directly to the provider that was subject to the review. Objective findings and recommendations for improvement of deficiencies shall be included in the report. Any provider scoring below ninety percent (90%) will be given thirty (30) days to submit and ninety (90) days to complete a corrective action plan. Upon completion of the corrective action plan, a repeat office site review will be performed. The completed Site Evaluation Form will be placed in the provider’s credentialing and quality of care file for review by the credentialing committee.
Medical Record Requirements

Providers shall keep members’ medical records confidential in compliance with State and federal laws regarding confidentiality of medical records. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. However, nothing shall limit timely dissemination of such records to authorized providers and consulting physicians, to governmental agencies as required and permitted by law, to accrediting bodies, to committees of provider, and to Cigna-HealthSpring for administrative purposes. To the extent permitted by law, Cigna-HealthSpring shall have the right to inspect at all reasonable times any medical records maintained by provider pertaining to Cigna-HealthSpring members. A provider agrees to maintain all medical records pertaining to treatment of members for a period of ten (10) years or, for minors, ten years past the attainment of age 21 years.

Medical Records shall not be removed or transferred from a provider except in accordance with general provider policies, rules, and regulations. Providers agree to furnish members timely access to their own records. Cigna-HealthSpring may audit a provider’s medical records for Cigna-HealthSpring members, as a component of Cigna-HealthSpring’s quality improvement, credentialing, and re-credentialing processes. Nursing Facility provider must furnish medical records within three (3) days upon request. In accordance with AMA guidance and NCQA guidelines, medical records must be legible with current details organized and comprehensive in order to facilitate the assessment of the appropriateness of care rendered. Documentation audits are performed to assure that Providers maintain a medical record system that permits prompt retrieval of information. Audits are also performed to assure that medical records are legible, contain accurate and comprehensive information, and are readily accessible to health care providers. Medical record review also provides a mechanism for assessing the appropriateness and continuity of health care services. Applicable regulations mandate medical record review by Cigna-HealthSpring. Criteria (indicators) to be evaluated include the following:

1. Demographic/personal data are noted in the record, complete member name, date of birth, home address and phone number, sex, marital status, insurance, and member identification number
2. An emergency contact person’s names, address, and phone number, or that there is no contact person is noted in the medical record
3. Each page of the medical record contains the member's name or member identification number
4. All entries are legible, signed and dated by the author and include credentials and title. Signature may be handwritten, stamped, or electronic
5. Significant illness, medical and psychological conditions are indicated on the problem/medical list and are listed in the front of the medical record
6. Prescribed medications, including dosage, date of initial and/or refill prescriptions are listed
7. There is evidence of member/caregiver education including medication review. Allergies and adverse reactions to medications are prominently noted in the record
8. The history and physical examination records indicate subjective and objective information pertinent to the member's presenting complaints
9. Past medical history, including serious accidents, surgeries and illnesses are noted in the medical record
10. Working diagnoses are consistent with the findings
11. Treatment plans are consistent with the diagnosis and are referenced in every applicable note
12. There is documentation that the member participated in the formulation of the treatment plan
13. All diagnostic and therapeutic services for which a member was referred by a provider are in the medical record and there is evidence that the provider reviewed these reports
14. There is explicit notation in the medical record of follow-up plans related to consultation, abnormal laboratory, and imaging study results
15. Chronic and/or unresolved problems previously identified are addressed in subsequent notes
16. There is no evidence that the patient is placed at risk by a diagnostic or therapeutic procedure
17. There is evidence that medical care is offered in accordance with Cigna-HealthSpring clinical care guidelines
18. The medical record contains appropriate notation concerning use of alcohol, cigarettes, and any substance abuse
19. There is notation regarding follow-up care, calls, or visits
20. The specific time of return is noted in days, weeks, months, or as needed
21. There is a separate medical record for each member
22. The documentation is consistent with the assigned ICD-10 codes
23. Only authorized staff has access to medical records
24. Medical records are easily located and retrieved
25. Forms used for documentation are consistent in all records
26. There is a completed immunization record in accordance with Cigna-HealthSpring preventive guidelines
27. The chart is orderly
28. Preventive screenings and services are offered/recommended
29. There is documentation of a discussion of a living will or advance directives and/or advance care planning for patients 18 years of age or older/or patients with life threatening conditions
30. Clinical findings and evaluations are documented.
31. Behavioral Health providers must have communicated with a member’s PCP initially and quarterly through a written summary report to advise the PCP of member’s treatment and medications, if any. This will be part of the Behavioral Health provider medical record review.

Providers must meet these requirements for medical record keeping. If opportunities for quality improvement are identified, Cigna-HealthSpring will present these opportunities and implement interventions.

Provider must comply with all provisions of the state-mandated requirements for STAR+PLUS Nursing Facility Providers. Provider must provide MCO access to members’ medical records,
allow access to the Facility and other premises where records are kept, and provide MCO with reasonable notice of and the opportunity to participate in care planning discussions and activities.

If at the time of request for access to medical records HHSC or OIG or another state or federal agency believes records are about to be altered or destroyed, the nursing facility must provide records at the time of request or in less than 24 hours.

**Credentialing for Nursing Facilities**
The credentialing process is a vital part of the Cigna-HealthSpring Quality Improvement Program and is an essential to ensuring that the care delivered is of optimal quality. All practitioner and organizational applicants to Cigna-HealthSpring must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. Once an application has been submitted, the provider is subject to a rigorous verification process that includes primary and secondary source verifications of all applicable information for the contracted specialty(s). Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied participation. The credentialing process may take up to sixty (60) days to complete once all application information and verifications are received. No provider can be assigned a health plan effective date or be included in a provider directory without undergoing the credentialing verification and peer review process. Once credentialing has been completed and the applicant has been approved, the provider will be notified by Network Operations of their participation effective date. Providers are advised to not see Cigna-HealthSpring members until they’ve received this notification. All providers who have been initially approved for participation are required to recredential at least once every three years in order to maintain their participating status.

**Credentialing Application for Physicians and Non-physician Practitioners Providing Add-on Services**
Providers rendering Add-on Services must refer to the Cigna-HealthSpring STAR+PLUS provider manual located on our website [http://starplus.cignahealthspring.com/](http://starplus.cignahealthspring.com/); or contact Provider Services at 1-877-653-0331.

**Credentialing Committee/Peer Review Process**
All initial applicants and re-credentialed providers are subject to a peer review process prior to approval or re-approval as a participating provider. Providers who meet all of the acceptance criteria may be approved by the Medical Director. Providers who do not meet established thresholds are presented to the credentialing committee for consideration. The credentialing committee is comprised of contracted primary care providers, specialty providers and LTSS representatives, and has the authority to approve, deny or terminate an appointment status to a provider. All information considered in the credentialing and re-credentialing process must be obtained and verified within one hundred eighty (180) days prior to presentation to the Medical Director or the credentialing committee. All providers must be credentialed and approved before being assigned a participating effective date.

**Ongoing Participation Requirements for all Cigna-HealthSpring Providers**
Once a provider is accepted for participation with Cigna-HealthSpring, he/she must continually maintain and comply with all Cigna-HealthSpring policies and procedures. This includes the following requirements:
Under their Cigna-HealthSpring Participating provider agreements, providers must notify Cigna-HealthSpring in writing within five (5) days of any changes in status relative to the established credentialing criteria or any other matter that could potentially affect a continued contractual relationship with Cigna-HealthSpring such as:

- Significant or prolonged illness
- Leave of absence
- Suspension or modification of privileges
- A change in physical or behavioral health status that affects the provider’s ability to practice
- Loss of accreditation status from any nationally recognized accreditation body
- Any other action that materially changes the provider’s ability to provide service to members

Providers who maintain more than one office location must include all offices locations in the Cigna-HealthSpring provider network.

Compliance with the after-hours coverage requirement defined in the "Provider Responsibilities" section of this provider manual.

If the provider's Cigna-HealthSpring Participating provider agreement is terminated involuntarily, a one-year period must elapse before the provider can reapply. Upon reapplication, all circumstances of the termination/resignation must be revealed and will be considered. If either party terminates the Cigna-HealthSpring Participating provider agreement or there is a break in service of more than thirty (30) calendar days, the practitioner shall be initially credentialed before rejoining the network.

Providers must inform both the MCO and HHSC’s administrative services contractor of any changes to the provider’s address, telephone number, group affiliation, etc.

**Re-Credentialing**

It is imperative that providers complete the re-credentialing process in order to remain in good standing and continue to treat Cigna-HealthSpring members. Providers must be formally re-credentialed every thirty-six (36) months. Three (3) separate attempts will be made to obtain the required information via mail, fax, email, or telephonic request during the data collection period. Non-compliance with the re-credentialing process in advance of the provider’s due date for re-credentialing will result in termination from the Cigna-HealthSpring provider network. The only exception shall be for providers who are on active military assignment, maternity leave, or sabbatical. In these cases, the provider shall be re-credentialed upon his or her return. The reason will be documented in the provider’s file and in applicable databases.

**Provider Rights - Credentialing and Re-Credentialing**

Providers' rights related to the Cigna-HealthSpring credentialing and re-credentialing process include:
The provider has the right to review information obtained from any outside source to evaluate their credentialing application and submitted to Cigna-HealthSpring in support of his or her credentialing/re-credentialing application except for peer review information that is confidential, protected, and restricted under state and federal peer review laws. The provider may submit a written request to review his/her file information at least thirty (30) days in advance at which time the plan will establish a time for the provider to view the information at the plan’s offices.

The provider has the right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the provider. He/she will be given the opportunity to clarify and/or correct the information prior to the finalization of the credentialing/re-credentialing process. In instances where there is a substantial discrepancy in the information, credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the credentialing department to either correct or dispute the alleged variation in their application information within thirty (30) days of notification.

The provider has the right, upon request, to be informed of the status of his/her credentialing or re-credentialing application. A provider may request the status of their application either telephonically or in writing. The plan will respond within two (2) business days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated review date, and approval status.

Credentialing and re-credentialing processes are conducted in a nondiscriminatory manner. Through the universal application of specific assessment criteria, Cigna-HealthSpring ensures fair and impartial decision-making in the credentialing process and does not make decisions based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients in which the provider specializes. All decisions are based on the aforementioned criteria.

Upon written request from an applicant or a provider who is already credentialed, Cigna-HealthSpring shall disclose the relevant credentialing criteria outlined above. Appeal rights apply to participating Cigna-HealthSpring providers who have been terminated from the provider network and new providers who have been denied initial credentialing, if the denial decision is based on adverse information or not meeting credentialing requirements. Cigna-HealthSpring does not offer appeal rights to any initial applicant who was denied due to quality of care issues or failure to meet Medicare and/or Medicaid participation requirements.

Cigna-HealthSpring will not exclude from credentialing or terminate a health care provider based solely on having a practice that includes a substantial number of patients with expensive medical conditions.

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

Cigna-HealthSpring will provide information regarding further provider rights in the event that a provider is denied credentialing.

**Confidentiality of Credentialing Information**

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

**Ongoing Monitoring**

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

**Provider Directory**

To be included in Provider Directories or any other member information, providers must be fully credentialed and approved. Directory specialty designations must be commensurate with the education, training, board certification and specialty(s) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by credentialing.

**Member Service**

**Special Access Requirements**

Cigna-HealthSpring provides services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities. Cigna-HealthSpring serves these members in a manner that recognizes values, affirms and respects their worth and protects and preserves the dignity of each. As such, Cigna-HealthSpring has implemented several key initiatives that are specifically designed to meet the special access needs of the STAR+PLUS population. These initiatives include a comprehensive cultural competency program, interpreter and translation services, and customized member materials that take into consideration variances in the population's reading levels.

**Cultural Sensitivity**

Cigna-HealthSpring ensures that all member communication is sensitive to the vast cultural differences spanning the STAR+PLUS population. Cigna-HealthSpring makes it a priority to
employ and develop associates who can communicate effectively with members of various ages and cultural backgrounds. Cigna-HealthSpring supports the belief that providing quality health care means treating the whole patient and not just the medical condition. Cultural sensitivity plays a key role in accomplishing this goal successfully. As such, Cigna-HealthSpring encourages and advocates for providers to provide culturally competent care for its members. Following is a list of cultural competency principles for health care providers to consider in the health care delivery process:

**Knowledge**
Knowledge and understanding of differences are essential components of cultural competency. To be culturally competent a provider must have an understanding of:

- Race, ethnicity and influence
- The historical factors which impact the health of minority populations, such as racism and immigration patterns
- The particular psycho-social stressors relevant to minority patients including war trauma, migration, acculturation stress, and socioeconomic status
- The cultural differences within minority groups
- The minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network
- The differences between "culturally acceptable" behavior of psychopathological characteristics of different minority groups
- Indigenous healing practices and the role of religion in the treatment of minority patients
- The cultural beliefs of health and help-seeking patterns of minority patients
- The health service resources for minority patients
- Public health policies and their impact on minority patients and communities

**Skills**
To treat culturally-diverse populations successfully, health care providers must develop an ability to:

- Interview and assess minority patients based on a psychological/social/biological/cultural/political/spiritual model
- Communicate effectively with the use of cross cultural interpreters
- Diagnose minority patients with an understanding of cultural differences in pathology
- Avoid under-diagnosis or over-diagnosis
- Formulate treatment plans that are culturally sensitive to the member's and family's concept of health and illness
- Utilize community resources such as church, community-based organizations (CBOs), and self-help groups
- Provide therapeutic and pharmacological interventions, with an understanding of the cultural differences in treatment expectations and biological response to medication
- Request for consultation

**Attitudes**
Aside from having the knowledge and skill set to treat culturally-diverse populations, health care providers must adopt positive attitudes and foster respect for their patients. This includes respecting and appreciating the:

- "Survival merits" of immigrants and refugees
- Importance of cultural forces
- Holistic view of health and illness
- Importance of spiritual beliefs
- Skills and contributions of other professional and paraprofessional disciplines
- Transference and counter transference issues

**Interpreter/Translation Services**

Cigna-HealthSpring ensures its staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. Cigna-HealthSpring arranges for language interpretation services for over 170 languages through TeleLanguage. TeleLanguage can be accessed by calling the Cigna-HealthSpring Provider Services Department at 1-877-653-0331. For telephone-interpreting service for the deaf, hard of hearing, deaf-blind, or speech impaired Cigna-HealthSpring can be reached using the State Relay Service (711).

Trained interpreters must be used when technical, medical, or treatment information is discussed. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality or confidentiality is critical unless specifically requested by the member.

**Reading/Grade Level Consideration**

All Cigna-HealthSpring member materials and website content are specially designed to take into consideration the STAR+PLUS population's needs. Materials are intended to be user-friendly and concise and they are written at a reading level that is at or below 6th grade as measured by the Flesch Reading Ease Test.

All member materials regarding advance directives are written at a 7th - 8th grade reading comprehension level, except where a provision is required by State or federal law and the provision cannot be reduced or modified to a 7th - 8th grade reading level because it is a reference to the law or is required to be included “as written” in the State or federal law.

**Direct Access to a Specialty Care Provider for Members with Special Health Care Needs**

Specialty Care Providers can act as PCPs under specific circumstances as long as the Specialist agrees to be a PCP. A Specialty Care Provider may be designated by Cigna-HealthSpring as a PCP for members who require a specialized physician to manage their specific health care needs such as those living with HIV or AIDS. Children and adults with special health care needs also may designate a Specialty Care Provider as a PCP to coordinate their care. A Specialty Care provider acting in the PCP role must agree to adhere to Cigna-HealthSpring's PCP standards. To request to be a PCP, Specialty Care Providers should call the Cigna-HealthSpring Provider Services Department at 1-877-653-0331.
General Transportation and Ambulance/Wheelchair Van
The Nursing Facility is responsible for providing general routine non-emergency transportation services. The cost of such transportation is included in the Nursing Facility unit rate. Transports of Nursing Facility residents for rehabilitative treatment (e.g., physical therapy), to outpatient departments, or to physicians’ offices for recertification examinations for Nursing Facility care are not reimbursable services by Cigna-HealthSpring.

Cigna-HealthSpring is responsible for authorizing non-emergency ambulance transportation for a resident whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

MCO/Provider Coordination
Cigna-HealthSpring and health care providers coordinate services to ensure holistic treatment and appropriate utilization of health care resources. These duties are to improve members’ access to services and health outcomes, while ensuring proper allocation of benefits.

Member Rights and Responsibilities

Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect
   b. Know that your medical records and discussions with your providers will be kept private and confidential

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
b. Say yes or no to the care recommended by your provider.

5. You have the right to use each available complaint and appeal process through the managed
care organization and through Medicaid, and get a timely response to complaints, appeals, and
fair hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health
care, your provider, or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan’s appeal process and be told how to use it.
   d. Ask for a fair hearing from the state Medicaid program and get information about how
that process works.

6. You have the right to timely access to care that does not have any communication or physical
access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any
emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider’s office. This includes barrier free
access for people with disabilities or other conditions that limit mobility, in accordance
with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking
to your health plan. Interpreters include people who can speak in your native language,
help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the
health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else’s convenience,
or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you
about your health status, medical care, and treatment. Your health plan cannot prevent them from
giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services.
Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for
covered services.

Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That
includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan’s and Medicaid’s policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan’s rules and Medicaid rules.
   b. Choose your health plan and a primary care provider quickly.
   c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.

**Member’s Right to Designate an OB/GYN**

MCO DOES NOT LIMIT TO NETWORK

Cigna-HealthSpring allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member’s Primary Care Provider or not

**Attention female members:**
Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:
   - One well-woman checkup each year
   - Care related to pregnancy
   - Care for any female medical condition
   - A referral to a specialist doctor within the network

**Member Complaint and Appeal Process**
Cigna-HealthSpring's member complaint and appeal process is designed to facilitate prompt resolution to member issues and promote member satisfaction. Cigna-HealthSpring’s member handbook contains a written description of Cigna-HealthSpring’s complaint process in a format
that is easy to understand. Additionally, Cigna-HealthSpring has member advocates who are available to help members file complaints, if necessary.

A **Complaint** means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an action. As provided by 42 C.F.R. 438.400, possible subjects for complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid member’s rights.

An **Action** means
1. The denial or limited authorization of a requested Medicaid service, including the type or level of service
2. The reduction, suspension, or termination of a previously authorized service
3. The denial in whole or in part of payment for service
4. The failure to provide services in a timely manner
5. The failure of an MCO to act within the timeframes set forth in the Contract and 42 C.F.R 438.408(b)
6. For a resident of a rural area with one MCO, the denial of a Medicaid member’s request to obtain services outside of the Network.

An **Adverse Determination** is one type of Action.

An **Appeal** is a formal process by which a member or his or her representative requests a review of the MCO’s Action, as defined above.

An **Authorized Representative** is any person or entity acting on behalf of the member, for whom Cigna-HealthSpring has received the member’s written consent. A provider may be an authorized representative.

**Expedited Appeal** means an appeal to the MCO in which the decision is required quickly based on the member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

**Member Complaint Process**
The member has the right to file complaints to Cigna-HealthSpring, HHSC’s Administrative Services Contractor, DADS, and the Texas Long Term Care Ombudsman. Member complaints can be filed verbally or in writing by contacting Cigna-HealthSpring as follows:

- Fax written Member Complaints to 1-877-809-0783
- Mail them to:
  Cigna-HealthSpring
  Appeals and Complaints Department
  P.O. Box 211088
  Bedford, Texas 76095
• Contact Member Services at 1-877-653-0327, Monday to Friday, 8 a.m. to 5 p.m. Central Time,

A Cigna-HealthSpring member Advocate is available to help file a complaint if necessary.

If a complaint is received verbally by telephone, Cigna-HealthSpring’s Provider Services representatives collect detailed information about the complaint and route the complaint electronically to the appeals and complaints department for handling. Within five (5) business days of receipt of a complaint, Cigna-HealthSpring sends the member or the member's authorized representative a letter acknowledging receipt of the complaint. The acknowledgement letter will include the date the complaint was received, a description of the complaint process, and the timeline for resolution. Cigna-HealthSpring will investigate the complaint and take corrective action if necessary. Cigna-HealthSpring will issue a response letter to the member or the member's authorized representative within thirty (30) calendar days from the date the complaint was received. The response letter will include a description of the resolution and the process to appeal the complaint if the member or the member's authorized representative is not satisfied with Cigna-HealthSpring's decision.

Cigna-HealthSpring will ensure that every complaint, whether received by telephone or in writing, will be recorded with the following details:

1. Date
2. Identification of the individual filing the complaint
3. Identification of the individual recording the complaint
4. Nature of the complaint
5. Disposition of the complaint (i.e., how the complaint was resolved)
6. Corrective action required
7. Date resolved

If members are not satisfied with Cigna-HealthSpring’s resolution to a complaint, they can file a complaint with the HHSC by calling 1-888-566-8989 or by writing to:

Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If the member has Internet access, he/she can email to HPM_Complaints@hhsc.state.tx.us.
Members must exhaust the MCO’s complaint process prior to contacting HHSC.

**Member Appeal Process**
If a covered service is denied, delayed, limited, or stopped, Cigna-HealthSpring will notify the member in writing and provide an appeal form with instructions on how to file an appeal. Members have the option to request an appeal for denial of payment of services in whole or in part within 30 days from the date Cigna-HealthSpring did not approve the service. Members
may request an appeal verbally or in writing by within 30 days from the date Cigna-HealthSpring did not approve the service. Contact Cigna-HealthSpring as follows:

- Fax written Member Appeals to 1-877-809-0783
- Mail them to:
  Cigna-HealthSpring
  Appeals and Complaints Department
  P.O. Box 211088
  Bedford, Texas 76095
- Contact Member Services at 1-877-653-0327, Monday to Friday, 8 a.m. to 5 p.m. Central Time,

A Cigna-HealthSpring member Advocate is available to help file an appeal if necessary.

If an appeal is received verbally by telephone, Cigna-HealthSpring will send the member or member’s authorized representative an appeal form to document the appeal, unless an expedited appeal is requested. Instructions for where to return the completed appeal form will be included with the appeal form. If Cigna-HealthSpring does not receive the signed appeal form within thirty (30) days from the date the appeal request was received, the appeal will not be reviewed and the case will be closed. Within five (5) days of receipt of a signed appeal form or a written appeal, Cigna-HealthSpring will send written acknowledgement to the member or the member's authorized representative. The acknowledgement letter will include the date the appeal was received, a description of the appeal process, and the timeline for resolution.

In order to ensure continuity of currently authorized services, the member may request continuation of services while an appeal is being reviewed. To do so, the member must file the appeal on or before the later of ten (10) days following the mailing of the Action or the intended effective date of the proposed action. The member may be required to pay the cost of the services furnished while the appeal is pending, if the final decision is adverse to the member. If Cigna-HealthSpring receives an oral request for an appeal, it must be confirmed by an appeal form signed by the member or the member's authorized representative; unless an Expedited appeal is requested.

Cigna-HealthSpring mails an acknowledgement letter to a member or the member's authorized representative within five (5) business days of receipt of the written appeal, acknowledging the date of receipt and indicating the document(s) that the appealing party must submit for review and date by which the document(s) is due.

Within thirty (30) calendar days of receipt of the appeal, Cigna-HealthSpring responds in writing to the member or the member's authorized representative and to the member’s provider. The member or Cigna-HealthSpring may request that the timeframe for resolving an appeal be extended by up to fourteen (14) calendar days if there is a need for more information that will influence the determination on the appeal. If an extension is requested, Cigna-HealthSpring sends a letter to the member or the member's authorized representative and to the member’s provider, explaining the reason for the delay.
If the appeal is denied, the appeal determination letter includes a clear statement of the clinical basis for the denial, the specialty of the physician or other health care provider making the denial and the appealing party’s right to seek review of the denial through the Fair Hearing process.

For appeals related to Level of Care determinations, the member or member’s authorized representative will be directed to contact the Administrative Services Contractor. Cigna-HealthSpring will also coordinate with HHSC’s Administrative Services Contractor for all MDS Medical Necessity Level of Care appeals.

**Member Expedited Appeal**
Cigna-HealthSpring maintains an expedited appeal process in the event that the member or the member's authorized representative states orally or in writing in the appeal that the member’s health or life is in serious jeopardy as a result of the Adverse Determination. A member Advocate is available to help file an Expedited appeal, if necessary. If Cigna-HealthSpring accepts the request for an expedited resolution, the request is investigated and a resolution is provided to the member or the member's authorized representative within three (3) business days, except if the Expedited appeal is related to an ongoing emergency or denial of continued hospitalization. In these cases, the Expedited appeal must occur in accordance with the medical or dental immediacy of the case, but not later than one (1) business day after receiving the member’s request for Expedited appeal.

If Cigna-HealthSpring determines the member’s health or life is not in serious jeopardy and denies the request for an expedited reconsideration, the member or the member's authorized representative is immediately informed orally and a written notice follows within two (2) calendar days. The appeal becomes subject to standard appeal timeframes.

Written notification of the outcome of the Expedited appeal is issued as soon as possible, but no later than three (3) calendar days after the date Cigna-HealthSpring receives the appeal. If the member or the member's authorized representative is not satisfied with Cigna-HealthSpring’s decision, he/she may file an appeal with the State. Members have the right to appeal directly to the State any time during or after Cigna-HealthSpring’s appeal process. If the member does not agree with decision, he/she may request a Fair Hearing from the State. The member or the member's authorized representative must first exhaust Cigna-HealthSpring's internal Expedited appeal process prior to requesting an Expedited Fair Hearing.

**Member Request for State Fair Hearing**
If a member, as a member of the health plan, disagrees with the health plan’s decision, the member has the right to ask for a fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent him or her. A provider may be the member’s representative. The member or the member’s representative must ask for the fair hearing within 90 days of the date on the health plan’s letter that tells of the decision being challenged. If the member does not ask for the fair hearing within 90 days, the member may lose his or her right to a fair hearing. To ask for a fair hearing, the member or the member’s representative should either send a letter to the health plan at:
If the member asks for a fair hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the member does not request a fair hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped.

If the member asks for a fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most fair hearings are held by telephone. At that time, the member or the member’s representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

At any time during the appeal process or after Cigna-HealthSpring upholds an Action of an appeal, the member or the member's authorized representative may seek review of that appeal determination through the Fair Hearing process.

If the member of authorized representative disagrees with Cigna-HealthSpring’s decision, then he/she has right to ask for a Fair Hearing. The member may name someone to represent him/her by informing Cigna-HealthSpring in writing of the name of the person he/she wants representing them. A provider may be the member’s representative. The member or the member's authorized representative must ask for the Fair Hearing within ninety (90) days of the date on the health plan’s letter that tells of the decision being challenged. If the member or the member's authorized representative does not ask for the Fair Hearing within ninety (90) days, the member may lose his or her right to a Fair Hearing. To ask for a Fair Hearing, the member or the member's authorized representative should contact Cigna-HealthSpring as follows:

- Fax written Member State Fair Hearings to Cigna-HealthSpring Appeals & Complaints Department at 1-877-809-0783
- Mail them to:
  Cigna-HealthSpring
  Appeals and Complaints Department
  P.O. Box 211088
  Bedford, Texas 76095
A Fair Hearing request must involve one of the following:

- The member is told that they do not qualify for Medicaid services
- The member applied for Medicaid services and the request is not acted upon promptly
- The member is told that Medicaid services are stopped or suspended
- The member is told that Medicaid services have been reduced

If the member or the member's authorized representative asks for a Fair Hearing within ten (10) days from the time he/she gets the hearing notice from Cigna-HealthSpring, the member or the member's authorized representative has the right to continue receiving the service(s) Cigna-HealthSpring denied, at least until a decision is made at the Fair Hearing. However, if Cigna-HealthSpring’s denial is upheld in the Fair Hearing, the member may be responsible for the cost of any services he/she received while the appeal was pending. If the member or the member's authorized representative does not request a Fair Hearing within ten (10) days from the time he/she gets the hearing notice, the service the health plan denied will be stopped.

If the member or the member's authorized representative asks for a Fair Hearing, he/she will get a packet of information letting him/her know the date, time, and location of the hearing. Most Fair Hearings are held by telephone. At that time, the member or the member's representative can tell why he/she needs the service Cigna-HealthSpring denied.

HHSC will give the member or the member's representative a final decision within ninety (90) days from the date the member or the member's authorized representative asked for the hearing.

**MMP (Medicare-Medicaid Plan)**

**Medicare-Medicaid Plan Program Overview**

Cigna-HealthSpring is participating in the Medicare-Medicaid Alignment Initiative as of March 1, 2015. The goal of this initiative is to better serve both community and institutional based individuals who are eligible for both Medicare and Medicaid (dual-eligible enrollees). The initiative is to develop a service delivery model that improves care coordination of services, improves quality of care, and reduces cost.

Providers should use this provider manual in conjunction with the Cigna-HealthSpring participating provider agreement to understand important participation requirements such as:

- Services that are covered under Cigna-HealthSpring
- How to determine Member eligibility
- How to access health care services within Cigna-HealthSpring’s network
- How to file claims with Cigna-HealthSpring
- Provider roles and responsibilities
Objectives of the MMP Program
The objective of the MMP Program is to:

- Make it easier for Members to get 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 service.

Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Eligibility
CMS and HHSC shall have sole responsibility for determining the eligibility of an Enrollee for a Medicare-Medicaid Plan. The Enrollee will be required to meet all criteria below: People age 21 or older and

- Get Medicare Part A, B and D, and are receiving full Medicaid benefits
- Eligible for or enrolled in the Medicaid STAR+PLUS program, which serves members who have disabilities and those who meet a nursing facility level of care and get STAR+PLUS home and community based waiver services

Certain Medicaid Members are excluded from enrolling in a Medicare-Medicaid Plan. This includes:

- Individuals under the age of 21
- Individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions (ICF/IIDs)
- Individuals receiving services through the following section 1915(c) waivers will be excluded from the demonstration
  - 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)

Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Enrollment
Once a Medicaid Member is determined by CMS and HHSC to be eligible for a Medicare-Medicaid Plan, he/she will receive letter in the mail from HHSC’s administrative services contractor, MAXIMUS. The letter contains information about the Medicare-Medicaid Plan, instructions for remaining with the Medicare-Medicaid Plan chosen for them, changing plans or
opting-out of the demonstration. MAXIMUS processes Medicare-Medicaid Plan applications, assists members who are transitioning from traditional, fee-for-service Medicare or Medicaid into the Medicare-Medicaid Plan and assists members in selecting an MCO and a PCP. Members who need assistance can contact an enrollment counselor by calling the MAXIMUS Helpline at 1-800-782-6440.

Because Medicare-Medicaid Plan members may change health plans, lose Medicaid eligibility, or change PCPs routinely, it is crucial for providers to verify member eligibility prior to rendering services. If a provider does not verify eligibility prior to rendering services and the member is determined later not to be a Cigna-HealthSpring member, then Cigna-HealthSpring cannot reimburse the provider for his/her services. Eligibility verification prior to every visit is essential to ensuring providers receive payment for services rendered. It is recommended to verify eligibility every first of the month since members can switch health plans every month.

**Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Disenrollment**

Member disenrollment from Cigna-HealthSpring may occur if the member:

- Selects another Medicare-Medicaid Plan
- Decides to Opt-out of the Demonstration
- Moves out of the Service Area for more than six (6) months
- Is determined to have Third-Party Coverage
- Is incarcerated
- Is no longer eligible for MMP

A member may request a disenrollment through the HHSC Administrative Services Contractor. If the member contacts Cigna-HealthSpring to request a disenrollment, Cigna-HealthSpring will direct the member to contact the MAXIMUS Helpline at 1-800-782-6440. Any time an individual requests to Opt-Out of Passive Enrollment or disenrolls from the Medicare-Medicaid Plan, the State or the Administrative Services Contractor will send a letter confirming the Opt-Out and disenrollment effective date in addition to providing information on the Medicaid benefits available to the beneficiary once they have opted out or disenrolled, and contact information to receive more information about Medicare benefits. If a member requests a voluntary disenrollment it will be processed as a complaint through Cigna-HealthSpring’s complaint process.

**Cigna-HealthSpring has a limited right to request involuntary member disenrollment**

Additionally, Cigna-HealthSpring may request involuntary disenrollment when there is evidence of member non-compliance such as:

- The member misuses or loans his/her identification card to another person to obtain services
- The member is disruptive, unruly, threatening or uncooperative to the extent that his/her membership seriously impairs Cigna-HealthSpring’s or the provider’s ability to provide services to the member or to obtain new members and the aforementioned behavior is not caused by a physical or behavioral health condition
- The member is steadfastly refusing to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the MCO to coordinate treatment of the underlying medical condition)
If a provider identifies a non-compliant member, the provider should call the Cigna-HealthSpring Provider Services Department at 1-877-653-0331 to report the concern. Cigna-HealthSpring will research the concern and decide if the situation warrants requesting an involuntary disenrollment through HHSC. Cigna-HealthSpring will document all attempts by the provider and Cigna-HealthSpring to rectify the situation. This may include member education and counseling. Then, Cigna-HealthSpring will submit the documentation to HHSC for review. HHSC’s Disenrollment Committee will review the disenrollment request. Within five (5) business days of receipt of all information necessary to complete the review, the Disenrollment Committee will make a final determination regarding the disenrollment request. HHSC will provide the member notice of its determination which will include information about the Appeal and Fair Hearing process. Cigna-HealthSpring cannot request a disenrollment based on adverse change in a member’s health status or utilization of services medically necessary for treatment of a member’s condition. Additionally, a provider cannot take retaliatory action against a member who is disenrolled from Cigna-HealthSpring. HHSC will make the final decision on any involuntary disenrollment request by Cigna-HealthSpring.

Facilitation of Services through the Service Coordinator
Once a care plan is established, the Service Coordinator works with the member’s PCP and the nursing facility staff to facilitate services, including access to Specialty Care Providers. At the member’s discretion, and with the Specialty Care Provider’s approval, the Specialty Care Provider may be designated as the member’s PCP. Authorization for office visits to an in-network Specialist is not required. Providers and members can reach the Cigna-HealthSpring Service Coordination Department by dialing 1-877-725-2688.

Under the Demonstration, skilled nursing level of care may be provided in a long term care facility without a preceding acute care inpatient stay for Enrollees, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.

Covered Services for Skilled Care
Cigna-HealthSpring CarePlan provides a benefit package to Medicare-Medicaid Plan members that include all medically necessary services covered under original Medicare/Medicaid programs. The following list provides an overview of these benefits. Providers can refer to the member’s Evidence of Coverage (EOC) for a more inclusive listing of limitations and exclusions. Medically necessary services that are not covered under original Medicare may be covered under managed Medicaid.

- Ambulance services
- Inpatient admissions to Acute Care facilities
- Skilled Nursing Facilities
- Inpatient behavioral health services Outpatient behavioral health services
- Psychiatry services
- Substance use disorder treatment services
- Residential services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Home health care services
- Laboratory services
- Optometry, glasses, and contact lenses, if medically necessary
- Audiology services for monoaural hearing aids
- Podiatry
- Primary care services
- Prescription medications of approved formulary (no limitation)
- Preventive services including an annual adult well check for members 21 years of age and over
- Radiology, imaging, and x-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision care

Cigna-HealthSpring Medicare-Medicaid Plan provides multiple covered screening services. Screening for certain disease process is very important for early detection and treatment.

**Covered Services for Wrap Services**
Cigna-HealthSpring will provide all LTSS services currently covered under the traditional, fee-for-service Medicaid program. The following is a non-exhaustive, listing of community-based, Long-Term Services and Supports included under Cigna-HealthSpring’s Medicare-Medicaid Plan. Providers should refer to the Medicare-Medicaid Plan Handbook for a more inclusive listing of limitations and exclusions that apply to each benefit category. The Medicare-Medicaid Plan Handbook is available at: http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/index.html.
Long-term Care Services Available to Medicare-Medicaid Plan Members

**Covered Supplies under Part B**
Part B covered services are the same as Original Medicare. Part B covers services such as physician charges and outpatient care. Part B will also assist in covering services that Part A doesn't cover such as medically necessary physical and/or occupational therapies and home health care.

**Behavioral Health Services**
Behavioral Health Services means covered services for the treatment of mental, emotional, or chemical dependency disorders. Cigna-HealthSpring provides a behavioral health benefit package to MMP members. The following list provides an overview of these benefits.

**Behavioral Health Services, including but not limited to:**
- Inpatient mental health services for adults and children
- Outpatient mental health services for adults and children
- Partial Hospitalization (PHP) and Intensive Outpatient Services (IOP)
- Psychiatry services
• Counseling services for adults (21 years of age and over)
• Electroconvulsive therapy (ECT)
• Psychological Testing
• Targeted Case Management Services
• Mental Health Rehabilitation Services
• Cognitive Rehabilitation Therapy

Substance use disorder treatment services, including but not limited to:
• Detoxification services
• Medication assisted therapy (MAT)

Member Access to Behavioral Health Services
Cigna-HealthSpring members may access behavioral health services in several ways. They are as follows:

1. Through the PCP. A PCP may provide treatment within the scope of his or her practice and licensure using the DSM-V multi-axial classifications.
2. Through a provider referral. A PCP or Specialty Care Provider may refer a Cigna-HealthSpring member to an in-network Behavioral Health provider.
3. Through a self-referral. A member may self-refer for behavioral health services to any in-network Behavioral Health provider. To identify an in-network Behavioral Health provider, members can call their Service Coordinator at 1-877-725-2688. Also, members may call the Cigna-HealthSpring Member Service Department at 1-877-653-0327, Monday through Friday, 8 a.m. to 5 p.m. Central Time. Members in crisis can call Cigna-HealthSpring’s Crisis Hotline at 1-800-959-4941, seven (7) days a week, twenty-four (24) hours per day.
4. Through Service Coordinator referral. New members are assessed by Service Coordinators using the Health Risk Assessment (HRA). All Behavioral Health Referrals and Case Management Services are addressed by the Cigna-HealthSpring Behavioral Health Department. The Behavioral Health Department is comprised of licensed mental health clinicians who are able to assess a member’s needs, assist with accessing services, monitor treatment following discharge from an inpatient facility, assist providers with discharge planning needs, and provide resources for resolving psychosocial needs. A licensed clinician is available to speak with a member or provider to address treatment needs. In addition to licensed clinicians, the Behavioral Health Department includes experienced Behavioral Health Utilization Review Nurses who are responsible for reviewing and authorizing behavioral health services.
5. For the Tarrant SDA, the Behavioral Health Department also includes two co-located clinicians with Tarrant County MHMR who are available to assist with linking members to services provided by the Local Mental Health Authority (MHMR) and coordinating mobile crisis interventions as needed.

Freestanding Psychiatric Facilities for Children and Adults in MMP
Cigna-HealthSpring is responsible for reviewing and authorizing inpatient Hospital services, including services provided by in a Freestanding Psychiatric Facility.
**Prior Authorization Requirements for Behavioral Health Services**

Behavioral Health providers should notify Cigna-HealthSpring when they are initiating treatment. The notification process provides an opportunity to verify eligibility, confirm benefits, obtain prior authorization if necessary, and update the member’s electronic file within Cigna-HealthSpring’s system.

Prior authorization forms for behavioral health services can be obtained by visiting our provider portal at [https://starplus.hsconnectonline.com](https://starplus.hsconnectonline.com) (see Appendices for instructions) or calling Provider Services at 1-877-653-0331.

**Medical Record and Documentation**

When filing claims for behavioral health services, providers must use the DSM-V multi-axial classification system and report a complete diagnosis using the five (5) Axes. Behavioral health services require the development of a treatment plan. Documentation must always indicate date of service. Co-morbid physical health conditions should be noted in Axis 3 of the diagnosis.

**Medical Management/Utilization Management**

Cigna-HealthSpring is certified by the State of Texas as a Utilization Review Agent (URA) to perform medical management functions for members enrolled in the Cigna-HealthSpring MMP program. Cigna-HealthSpring coordinates physical and behavioral health services to ensure quality, timely, clinically-appropriate, and cost-effective care that results in clinically desirable outcomes. Cigna-HealthSpring’s goal is to improve members' health and well-being through effective ambulatory management of chronic conditions, resulting in a reduction of avoidable inpatient admissions.

**Utilization Review Criteria and Authorization Process**

For services that do require CHS to review for authorization, an authorization request form will be completed and faxed into the Utilization Management department. Texas Standard Prior Authorization form located in Appendixes of this manual is the preferred authorization form. However, other authorization forms will be accepted. Authorization forms can also be found on our website at: [http://starplus.cignahealthspring.com](http://starplus.cignahealthspring.com). The intake staff will enter the data into the documentation system and assign to a UM nurse to review. Using an evidenced-based medical necessity criteria tool, and/or other approved review criteria, the nurse will review the clinical information provided to establish medical necessity for the item/service. If the nurse can approve, an authorization approval letter will be sent to the servicing provider. If the UM nurse is unable to approve the service/item request with the clinical information provided, the UM nurse will send the request to the medical director for determination. The medical director will determine the medical necessity of the request. For MMP, the determination will be communicated to both the servicing provider and member. For in-network providers, the turnaround time from receipt of the request to determination is three business days. It is critical that Cigna-HealthSpring receives the necessary clinical to make a determination in a timely manner. For MMP members, an administrative denial will be issued for lack of clinical information. The UM nurses communicate with the assigned Service Coordinator as indicated.

Cigna-HealthSpring requires the Nursing Facilities to submit a Resident Transaction Form 3618 and/or Form 3619 to HHSC as timely as possible. Filing these forms updates eligibility on the
file the MCO receives from the state showing if the member has returned to the community or has entered a nursing facility.

**Member Complaint and Appeal Process**
If a covered service is denied, delayed, limited, or stopped, Cigna-HealthSpring CarePlan MMP will notify the member in writing and provide an appeal form with instructions on how to file an appeal. Members have the option to request an appeal for denial of payment of services in whole or in part within **60** days from the date Cigna-HealthSpring CarePlan MMP did not approve the service. Members may request an appeal verbally or in writing by contacting Cigna-HealthSpring CarePlan MMP. Provider can refer to the Member Complaint and Appeal Process section for submission the process.

- Fax written claims appeals or complaints to the Cigna-HealthSpring Appeals & Complaints Department at 1-877-809-0783
- Mail them to:
  Cigna-HealthSpring
  Appeals and Complaints Department
  P.O. Box 211088
  Bedford, Texas 76095
- Log into HS Connect to access our Claims portal: [https://starplus.hsconnectonline.com](https://starplus.hsconnectonline.com)

Appeals for Medicare Parts A and B that result in an upheld decision regarding Adverse Actions will be auto-forwarded to the Medicare Part C Independent Review Entity (IRE). If the resolution of the IRE is not wholly in favor of the member, the member or his/her authorized representative may then file a request for hearing with an Office of Medicare Hearings and Appeals Administrative Law Judge.

Appeals for Part D drug denial must be responded to by Cigna-HealthSpring CarePlan within seven calendar days of receipt. Should a decision not be provided within the seven days, the member’s request will be automatically forwarded to the IRE.

Members who are utilizing the fast appeal process for Part D denials will be provided an answer within 72 hours of receipt of the appeal. If an answer is not provided with the 72 hours, the member’s request will be automatically forwarded to the IRE.

**Value-Added Services**
Medicare-Medicaid Plan MMP offers extra services in addition to Medicare and Medicaid services, and cannot be used in place of Medicare or Medicaid services. These benefits have been added to Cigna-HealthSpring’s Medicare-Medicaid Plan (MMP) in order to promote healthy lifestyles and improve health outcomes for members.

Initially, Cigna-HealthSpring notifies new members in the Welcome Kit regarding the available value-added services and how to access them. Thereafter, Cigna-HealthSpring sends benefit education materials to members annually, outlining the available value-added services and how to access them. Additional details about value-added services are available at [http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/index.html](http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/index.html). Cigna-HealthSpring
members can get assistance accessing value-added services from their Service Coordinator by calling 1-877-725-2688 or by calling Member Service at 1-877-653-0327 Cigna-HealthSpring’s Value-Added Services are listed in the chart on the following pages:

<table>
<thead>
<tr>
<th>Value Added Service</th>
<th>Contact Information</th>
<th>Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in a Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra Help Getting a Ride</td>
<td>Cigna-HealthSpring Member Service Department 1-877-653-0327</td>
<td>Unlimited round trip transportation provided for plan-approved locations when other transportation cannot be accessed.</td>
</tr>
<tr>
<td>Extra Dental Services for Adults (age 21 and older)</td>
<td>DentaQuest -Providers: 1-888-308-9345 DentaQuest -Members: 1-855-418-1628</td>
<td>Members have a benefit of up to $500.00 each year for dental services that include oral examinations, X-rays, prophylaxis (cleaning), restorative services and simple extractions.</td>
</tr>
<tr>
<td>Extra Vision Services</td>
<td>Superior Vision 1-800-879-6901 Cigna-HealthSpring Member Service Department 1-877-653-0327</td>
<td>Members obtain an eye exam, a pair of glasses and an additional allowance of up to $100.00 for enhanced frame selection every 12 months.</td>
</tr>
<tr>
<td>Drug Store Services</td>
<td>Cigna-HealthSpring Member Service Department 1-877-653-0327</td>
<td>Members have access to over-the-counter (OTC) benefit not covered by the Texas Vendor Drug Program through a mail-order program. This service is branded as the Cigna-HealthSpring CarePack benefit. The program will include a formulary also known as the CarePack Catalogue of over-the-counter drugs and items not requiring a prescription. Monthly Limit of $20.</td>
</tr>
<tr>
<td>Health and Wellness Services</td>
<td>Cigna-HealthSpring Service Coordination 1-877-725-2688</td>
<td>Members will have access to Fitness Coach, an exercise fitness program that provides the self-care and motivation they need to adopt healthier lifestyles. Members have a choice of two (2) Fitness Coach Home Fitness Kits or facility membership. Home Fitness Kits are for Members who reside in a Nursing Facility who are unable to utilize a Fitness facility.</td>
</tr>
<tr>
<td>Gift Programs</td>
<td>Cigna-HealthSpring Member Service</td>
<td>• One cold and flu kit per member each year • One personal hygiene kit per member each</td>
</tr>
</tbody>
</table>
### Value Added Service

<table>
<thead>
<tr>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department 1-877-653-0327</td>
</tr>
</tbody>
</table>

### Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in a Nursing Facility

- Department 1-877-653-0327
- 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.

#### Billing and Claims Administration

**Claim Filing Formats for Unit Rate Services and Medicare Coinsurance**

Cigna-HealthSpring accepts claims in electronic formats. Electronic claims are the preferred method of submission. Electronic claims can be submitted to Cigna-HealthSpring through Change Healthcare (formerly Emdeon), or TMHP (TexMedConnect/ the TMHP EDI Gateway) or Availity (formerly T.H.I.N.), or PayerPath, or through HS Connect, which is Cigna-HealthSpring’s provider portal.

Electronic claims must be submitted using the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. For additional information refer to Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information).

The Cigna-HealthSpring Payer ID is 52192. Questions regarding Change Healthcare (formerly Emdeon) electronic claims submission can be directed to Change Healthcare (formerly Emdeon) at 1-800-845-6592 or providers may refer the Change Healthcare (formerly Emdeon) website at [http://changehealthcare.com](http://changehealthcare.com/). Nursing Facility providers may also submit claims through an HHSC-designated portal.

**Claims Medicare Coinsurance**

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.

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 30 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.

**Claims Acute Care Services**
For members who have acute care services to be authorized, MCOs will be responsible for authorization such as an acute facility admission, other services out of the scope of the Unit Rate Services and the Add-on Services. For authorization and claims information process, the nursing facility must refer to the STAR+PLUS provider manual section called Billing and Claims Administration. The Nursing Facility Provider can also contact Provider Services department at 1-877-653-0331.

**Provider Complaint and Appeal Process**
Providers must request claim appeals within 120 days from the date of remittance of the Explanation of Payment (EOP). Cigna-HealthSpring will process the appealed claim and adjudicate the claim within 30 days from the date of receipt of appeal. A provider may appeal any disposition of a claim. Cigna-HealthSpring will utilize the same submission process as indicated on the Provider Complaint and Appeal Process sections. Refer to the Provider Complaint and Appeal Process section, or contact Provider Services department at 1-877-653-0331 for additional information.

- Fax written complaint and claims appeals to the Cigna-HealthSpring Appeals & Complaints Department at 1-877-809-0783
- Mail them to:
  Cigna-HealthSpring
  Appeals and Complaints Department
  P.O. Box 211088
  Bedford, Texas 76095
- Log into HS Connect to access our Claims portal: https://starplus.hsconnectonline.com

**Continuing Provider Training**
Cigna-HealthSpring ensures that all providers are properly trained. Trainings are offered via webinar, by the representative or online. Refer to our MMP Provider website at https://www.cigna.com/medicare/healthcare-professionals/tx-mmp. The Cultural Competency and SNP MOC provider trainings are mandatory for each provider in direct contact with members to complete. To determine if this training needs to be completed by your facility, contact Provider Services Department by calling 1-877-653-0331.

Methods for completing the training
- Visit our Provider Website
- Contact your Representative
- Email Provider Training inbox
Appendices
Appendix A, Cigna-HealthSpring STAR+PLUS Member Identification Card

Medicaid Eligibility Only

2017 ID Card Star+Plus

1) The Cigna-HealthSpring and STAR+PLUS Logos
2) Member’s Medicaid Member ID#, issued by HHSC
3) Member’s Name
4) The name of Member’s Primary Care Provider
5) The phone number of Member’s Primary Care Provider
6) The Date Member is assigned to their PCP

Front

7) The Member Service phone number, available Monday to Friday, 8 a.m. to 5 p.m. Central Time
8) The TTY number for Hearing Impaired Members. For additional Hearing Impaired services, please contact TTY/Texas Relay at 1-800-735-2989 (English) or 1-800-662-4954 (Spanish)
9) The Service Coordination Department phone number
10) The Behavioral Health Crisis Hotline number
11) Provider Prior Authorization phone number
12) The address where providers send claims
Appendix B, Cigna-HealthSpring STAR+PLUS Member Identification Card

Medicare & Medicaid Dual Eligible Member

How to read CIGNA-HEALTHSPRING’S ID Card: Medicare and Medicaid Dual Eligible

Front
1) The Cigna-HealthSpring and STAR+PLUS Logos
2) Member’s Medicaid Member ID#, issued by HHSC
3) Member’s Name

Back
4) The Member Service phone number, available Monday to Friday, 8 a.m. to 5 p.m. Central Time
5) The TTY number for Hearing Impaired Members. For additional Hearing Impaired services, please contact TTY/Texas Relay at 1-800-735-2989 (English) or 1-800-662-4954 (Spanish).
6) The Service Coordination Department phone number
7) The Behavioral Health Crisis Hotline number.
8) Provider’s Prior Authorization phone number
9) The address where providers send claims
Appendix C, Cigna-HealthSpring CarePlan (MMP) Member Identification Card

Medicare & Medicaid Dual Eligible Member

How to read Cigna-HealthSpring ID Card: Medicare and Medicaid Dual Eligible

Front

1) The Cigna-HealthSpring and Medicare-Medicaid Plan Logos

2) Member’s Name

3) Member’s ID #, issued by Cigna-HealthSpring

4) Member’s Medicaid Member ID#, issued by HHSC

Back

5) The Member Service phone number, available Monday to Friday, 8 a.m. to 8 p.m. Central Time

6) The Behavioral Health Crisis Hotline number.

7) The Service Coordination Department phone number

8) The TTY number for Hearing Impaired Members. For additional Hearing Impaired services, please contact TTY/Texas Relay at 1-800-735-2989 (English) or 1-800-662-4954 (Spanish).

9) Provider’s Prior Authorization phone number

10) The address where providers send claims

11) Claims inquiry phone number
Appendix D, Sample Texas Benefits Medicaid Card

Note to Provider:
Ask this member for the card from their Medicaid medical plan. Providers should use that card for billing assistance. No medical plan card? Pharmacists can use the non-managed care billing information on the back of this card.

Members: Keep this card with you. This is your medical ID card. Show this card to your doctor when you get services. To learn more, go to www.YourTexasBenefits.com or call 1-800-252-8263.


THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES.


Non-managed care Rx billing: RxBIN: 610084 / RxPCN: DRTXPROD / RxGRP: MEDICAID

T3-C4-1213

Need help? ¿Necesita ayuda? 1-800-252-8263
Appendix E, Sample Form 1027-A Temporary Medicaid Identification

MEDICAID ELIGIBILITY VERIFICATION

THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.

Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid identification form is lost or late. The client number must appear on all claims for health services.

<table>
<thead>
<tr>
<th>Date eligibility verified</th>
<th>Verification method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLIENT NAME</th>
<th>DATE OF BIRTH</th>
<th>CLIENT NO.</th>
<th>ELIGIBILITY DATES</th>
<th>MEDICARE CLAIM NO.</th>
<th>STAR/STAR+ PLUS HEALTH PLAN INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>FROM</td>
<td>THROUGH</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form 3887) for the current month. I have requested and received Form 1027-A, Medical Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

CAUTION: If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Signature: Client or Representative

Date

Office Address and Telephone No.

<table>
<thead>
<tr>
<th>Name of the Worker</th>
<th>Worker Number</th>
<th>Worker Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of the Supervisor</th>
<th>Supervisor Number*</th>
<th>Supervisor Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

* or Authorized Lead Worker
Appendix F, List of Prior Authorization Services – Acute, Long Term Support Services (LTSS) and Behavioral Health Services

Authorization Requirements (Medicaid STAR+PLUS only)
Phone: 877-726-2568  Fax 877-800-9786  Outpatient 877-800-9787
All Hospitalizations require authorization including Transplants.
Pre-scheduled, elective admissions must have prior authorization prior to admission.
Emergency inpatient admissions require notification by the close of the next business day following the admission.
All Non-Participating/Out-of-Network Providers require prior authorization for all outpatient and elective inpatient services.
Prior Authorization is required for the services listed below whether billed on UB-04 or HCFA 1500.

| Labs Place of Service 11, 22, or 51
|----------------------------------|
| Exceptions: LABS - The following routine lab services may be performed in a participating provider's office without authorization: 81001 * 81002 * 81003 * 81010 * 81013 * 82270 * 82271 * 82272 * 82273 * 82497 * 82562 * 83026 * 83028 * 84003 * 84004 * 84020 * 84024 * 85123 * 85125 * 85126 * 85127 * 86499 * 87004 * 87008.
| All other lab specimens should be drawn in the provider's office and sent to a participating lab provider such as Quest, CPI, LabCorp or ProPath. The provider will be reimbursed for the lab draw.
| All other lab services completed anywhere else must be authorized prior to services being rendered.

| Health Care Office Place of Service 11, 50, 71, 72
|----------------------------------|
| Disability: Ambulatory Blood Pressure Monitoring
| Chiropractic-for all services except manipulations, up to 6 visits
| Hearing Aids (requires 30-day trial)
| Pain Management
| Radiology: CT, MRI, MRA, PET
| Sleep studies
| Viscosupplementation: J7321, J7322, J7323, J7324, J7328, J7329
| Treatment with injection 11360 Eulimixamb, 10 mg
| Treatment with injection J9354 Ado-Trastuzumab Emtansine
| Home Health Place of Service 12
| ECI notification
| External feedings
| Nutritional Supplements
| Home Health disciplines:
| Home Health Aide
| Occupational therapy excluding initial evaluation
| Physical therapy excluding initial evaluation
| Skilled nursing excluding initial evaluation
| Speech therapy after evaluation. (Speech therapy is covered for members 20 and younger in the home setting. Speech therapy is not covered for adults in home setting)
| Hospice care notification only
| Transportation Place of Service 41/42
| Ambulance non-emergent air or ground

| LTSS and STAR+PLUS Waiver Services:
|----------------------------------|
| Personal Attendant Services (PAS)
| Protective Supervision
| Day Activity & Health Services (DAHS)
| Adult Foster Care (AFC)
| Assisted Living (AL)
| Emergency Response Services (ERS)
| Home Delivered Meals (HDM)
| Minor Home Modifications (MMM)
| Nursing Services and Therapy Services (LTSS)

| DME:
| All Miscellaneous Codes
| Any supplies/equipment requests that exceed Medicaid allowable benefit
| All equipment rentals
| All purchases over $500 (per claim line)
| Prosthetics/Orthotics
| All require authorization

| Home Health Place of Service 12
|----------------------------------|
| Pain Management Procedures
| Physical Therapy excluding initial evaluation
| Plastic and Reconstructive Surgery
| Radiology: CT, MRI, MRA, PET
| Sleep Studies
| Speech therapy excluding initial evaluation
| Sterilization – Prior authorization
| Statement required with claim
| Telemonitoring
| TMJ Procedures
| Transplant Evaluations
| Venous Pain Procedures

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### Appendix F, List of Prior Authorization Services – Acute, Long Term Support Services (LTSS) and Behavioral Health Services, cont.

<table>
<thead>
<tr>
<th>Behavioral Health Services</th>
<th>Prior Authorization Required</th>
<th>Benefit Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Inpatient Admissions</td>
<td>Yes</td>
<td>Including concurrent review as needed</td>
</tr>
<tr>
<td>Partial Hospital Program</td>
<td>Yes</td>
<td>4.5-6 Hours</td>
</tr>
<tr>
<td>Outpatient Initial Psychiatric/Counseling Assessment</td>
<td>Call 877-725-5688 to notify</td>
<td>Notification only, limited to 2 sessions per year with 6 months between each session.</td>
</tr>
<tr>
<td>Outpatient Psychotherapy/IOF</td>
<td>No for the first 30 visits Yes after 30 visits</td>
<td>Authorization required after a total of 30 visits by all providers. Submit requests when patient has reached 24 visits.</td>
</tr>
<tr>
<td>Outpatient Psychological and Neuropsychological Testing</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Outpatient Medication Management</td>
<td>No for the first 30 visits Yes after 30 visits</td>
<td>Authorization required after a total of 30 visits by all providers. Submit requests when patient has reached 24 visits.</td>
</tr>
<tr>
<td>Injections</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Outpatient Electroconvulsive Therapy (ECT)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Electroconvulsive Therapy – Inpatient Setting</td>
<td>Yes/No – See limitations</td>
<td>If admitted only for ECT – PA Required. If admitted for any other Behavioral Health issue – No PA Required for the ECT during an inpatient stay.</td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Assessment</td>
<td>No</td>
<td>1 per episode of treatment.</td>
</tr>
<tr>
<td>Ambulatory Detoxification</td>
<td>Yes</td>
<td>Limited to one encounter per day. May be covered for a medically appropriate duration of care based on treatment need for up to 21 days. Subject to concurrent review. Clients ages 20 and under can access additional days of services with medical necessity and prior authorization.</td>
</tr>
<tr>
<td>Residential Detoxification</td>
<td>Yes</td>
<td>Limited to one encounter per day. May be covered for a medically appropriate duration of care based on treatment need for up to 21 days. Limited to one encounter per day. Subject to concurrent review. Clients ages 20 and under can access additional days of treatment with prior authorization.</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>Yes</td>
<td>May be covered for a medically appropriate duration of care, with a maximum of 35 days per episode of care. Limited to 2 episodes of care in 6 month period, with evidence of medical need. Clients ages 20 and under may receive additional days of treatment with prior authorization.</td>
</tr>
<tr>
<td>Ambulatory Treatment (Outpatient) (Individual and Group Counseling)</td>
<td>Call 877-725-5688 to Notify on initial visit only Yes on the 24th visit</td>
<td>Includes 26 hours of individual counseling per calendar year and 135 hours of group counseling per calendar year. Clients ages 20 and under can access additional counseling services with prior authorization.</td>
</tr>
<tr>
<td>Medication Assisted Therapy (MAT)</td>
<td>Notification only</td>
<td>30 doses per rolling calendar month.</td>
</tr>
</tbody>
</table>
| Intensive Outpatient Program (IOP) | Yes | Includes 26 hours of individual counseling per calendar year and 135 hours of group counseling per calendar year. HFAI services are for Medicaid clients who are 50 years of age and younger. Prior Authorization request must document all the following criteria:
   1. The client has an underlying physical illness or injury.
   2. There are documented indications that biopsychosocial |
Appendix F, List of Prior Authorization Services – Acute, Long Term Support Services (LTSS) and Behavioral Health Services, cont.

<table>
<thead>
<tr>
<th>Service</th>
<th>Authorization Required?</th>
<th>Service Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Training and Support</td>
<td></td>
<td>ANSA/GANS must support the Mental Health Rehab/Targeted Case Management services requested. Service package deviations must contain supporting documentation.</td>
</tr>
<tr>
<td>Individual Services for Adult</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Group Services for Adult</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Individual Services for the Child/Adolescent (with or without other individual)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Group Services for the Child/Adolescent (with or without other group)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent Services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Skills Training and Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Services for Adult</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Group Services for Adult</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Individual Services for the Child/Adolescent (with or without other individual)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Group Services for child and adolescent</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual services</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Individual services rendered by a RN</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Group Services</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Group services rendered by a RN</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Individual crisis services</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Targeted Case Management (effective 09/01/14)

<table>
<thead>
<tr>
<th>Service</th>
<th>Authorization Required?</th>
<th>Benefit Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Mental Health Targeted Case Management (Adult)</td>
<td>Yes</td>
<td>32 units (8 hours) per calendar day for clients who are 18 years of age and older</td>
</tr>
<tr>
<td>Routine Case Management (Child and Adolescent)</td>
<td>Yes</td>
<td>32 units (8 hours) per calendar day for clients who are 17 years of age and younger</td>
</tr>
<tr>
<td>Intensive Case Management (Child and Adolescent)</td>
<td>Yes</td>
<td>32 units (8 hours) per calendar day for clients who are 17 years of age and younger</td>
</tr>
</tbody>
</table>

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Appendix G, Texas Standard Prior Authorization Form

**Texas Standard Prior Authorization Request Form for Health Care Services**

### Section I — Submission

<table>
<thead>
<tr>
<th>Issuer Name:</th>
<th>Phone:</th>
<th>Fax:</th>
<th>Date:</th>
</tr>
</thead>
</table>

### Section II — General Information

- **Review Type:** [ ] Non-Urgent [ ] Urgent [ ] Clinical Reason for Urgency: 
- **Request Type:** [ ] Initial Request [ ] Extension/Renewal/Amendment [ ] Prev. Auth. #:

### Section III — Patient Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
<th>DOB:</th>
<th>Sex: [ ] Male [ ] Female [ ] Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Name (if different):</td>
<td>Member or Medicaid ID #:</td>
<td>Group #:</td>
<td></td>
</tr>
</tbody>
</table>

### Section IV — Provider Information

<table>
<thead>
<tr>
<th>Requesting Provider or Facility</th>
<th>Service Provider or Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>NPI #:</td>
<td>NPI #:</td>
</tr>
<tr>
<td>Specialty:</td>
<td>Specialty:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Fax:</td>
<td>Fax:</td>
</tr>
<tr>
<td>Contact Name:</td>
<td>Phone:</td>
</tr>
<tr>
<td></td>
<td>Primary Care Provider Name (see instructions):</td>
</tr>
<tr>
<td>Requesting Provider’s Signature and Date (if required):</td>
<td>Phone:</td>
</tr>
<tr>
<td></td>
<td>Fax:</td>
</tr>
</tbody>
</table>

### Section V — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)

<table>
<thead>
<tr>
<th>Planned Service or Procedure</th>
<th>Code</th>
<th>Start Date</th>
<th>End Date</th>
<th>Diagnosis Description (ICD version)</th>
<th>Code</th>
</tr>
</thead>
</table>

- [ ] Inpatient  [ ] Outpatient  [ ] Provider Office  [ ] Observation  [ ] Home  [ ] Day Surgery  [ ] Other: ____________________________

- [ ] Physical Therapy  [ ] Occupational Therapy  [ ] Speech Therapy  [ ] Cardiac Rehab  [ ] Mental Health/Substance Abuse  [ ] Home Health (MD Signed Order Attached? [ ] Yes [ ] No)  (Nursing Assessment Attached? [ ] Yes [ ] No)  Number of Sessions: _________  Duration: _________  Frequency: _________  Other: ____________________________

- [ ] DME (MD Signed Order Attached? [ ] Yes [ ] No)  (Medicaid only: Title 19 Certification Attached? [ ] Yes [ ] No)  Equipment/Supplies (include any HCPCS codes): ____________________________  Duration: _________

### Section VI — Clinical Documentation (See Instructions Page, Section VI)

*An issuer needing more information may call the requesting provider directly at: ____________________________*
Appendix H, Outpatient Prior Authorization Form

MEDICAID Prior Authorization Request Form – OUTPATIENT

Please fax to: 1-877-809-0790 (Home Health Services) or 1-877-809-0787 (All Other Requests)
Phone: 1-877-725-2688

*Required Field – please complete all required fields to avoid delay in processing
Note: In an effort to process your request in a timely manner, please submit any pertinent clinical information (i.e., progress notes, treatment rendered, test/lab results or radiology reports) to support the request for services. Any request for a non-contracted provider must include documentation to substantiate the reason for the request. (When all required information has been submitted, we will complete your request within 3 business days.)

<table>
<thead>
<tr>
<th>Member Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Name:</strong></td>
</tr>
<tr>
<td><strong>Member DOB:</strong> / /</td>
</tr>
<tr>
<td><strong>Member ID:</strong></td>
</tr>
<tr>
<td><strong>Date of Service:</strong> / /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requesting Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCP/Requesting Provider:</strong></td>
</tr>
<tr>
<td>Contact Person:</td>
</tr>
<tr>
<td>*Phone #:</td>
</tr>
<tr>
<td>*Fax #:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referring to (servicing) provider information: If below fields are not answered, Cigna HealthSpring® will automatically assign Cigna HealthSpring’s participating provider network to the member:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Servicing Provider:</strong></td>
</tr>
<tr>
<td>□ Non-contracted</td>
</tr>
<tr>
<td>Tax ID #:</td>
</tr>
<tr>
<td>NPI#:</td>
</tr>
<tr>
<td>Contact Person:</td>
</tr>
<tr>
<td>*Phone #:</td>
</tr>
<tr>
<td>*Fax #:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Non-contracted</td>
</tr>
<tr>
<td>Tax ID #:</td>
</tr>
<tr>
<td>NPI#:</td>
</tr>
<tr>
<td>Contact Person:</td>
</tr>
<tr>
<td>*Phone #:</td>
</tr>
<tr>
<td>*Fax #:</td>
</tr>
</tbody>
</table>

If requesting a non-contracted provider/facility, please explain why:

<table>
<thead>
<tr>
<th>Type of Service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please check only one of the boxes:</td>
</tr>
<tr>
<td>□ ASC</td>
</tr>
<tr>
<td>□ Office Procedure</td>
</tr>
<tr>
<td>□ Home Health</td>
</tr>
<tr>
<td>□ MR/IR/ACT PET</td>
</tr>
<tr>
<td>□ Transplant Evaluation</td>
</tr>
<tr>
<td>□ Ambulance</td>
</tr>
<tr>
<td>□ PT/OT/ST</td>
</tr>
<tr>
<td>□ DME</td>
</tr>
<tr>
<td>□ Other</td>
</tr>
<tr>
<td>□ Cosmetic/Reconstructive</td>
</tr>
<tr>
<td>□ Medication</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis Code:</strong></td>
</tr>
<tr>
<td><strong>Diagnosis:</strong></td>
</tr>
<tr>
<td><strong>Procedure/Service Requested:</strong></td>
</tr>
<tr>
<td>□ CPT Code</td>
</tr>
<tr>
<td>□ HCPCS Code</td>
</tr>
<tr>
<td><strong>Procedure/Service Description:</strong></td>
</tr>
<tr>
<td><strong>Number of visits:</strong></td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
</tr>
<tr>
<td><strong>Frequency of visits:</strong></td>
</tr>
<tr>
<td><strong>Number of previous visits:</strong></td>
</tr>
</tbody>
</table>

*Is supporting Clinical Information Attached?* Yes No - Please summarize clinical information below

MCDTX 17 55675 PR Approved

122
Appendix I, Inpatient Prior Authorization Form

MEDICAID Prior Authorization Request Form INPATIENT
Please fax to: 1-877-809-0786 (Inpatient Request for Authorization)
Phone: 1-877-725-2688

* Required Field – please complete all required fields to avoid delay in processing
Note: In an effort to process your request in a timely manner, please submit any pertinent clinical information (i.e. progress notes, treatment rendered, test/lab results or radiology reports) to support the request for services. Any request for a non-contracted provider must include documentation to substantiate the reason for the request. (When all required information has been submitted we will complete your request within 3 business days.)

### Member Information:

*Member Name:

*Member DOB: / / *

*Member ID: *

*Date of Service: / / *

### Requesting Provider Information:

*PCPI/Requesting Provider:*

Contact Person: *

*Phone #: *

*Fax #: *

### Referring to (servicing) provider information: If below fields are not answered, Cigna HealthSpring® will automatically assign Cigna HealthSpring’s participating provider network to the member:

*Serving Provider:*

☐ Non-contracted

Tax ID #:

NPI#:

Contact Person: *

*Phone #: *

*Fax #: *

*Facility:*

☐ Non-contracted

Tax ID #:

NPI#:

Contact Person: *

*Phone #: *

*Fax #: *

If requesting a non-contracted provider/facility, please explain why:

### Type of Service:

Please check only one of the boxes:

☐ Inpatient Emergent Notification

☐ Skilled Facility

☐ Inpatient Rehab Admit

### Clinical Information:

*Diagnosis Code:*

Diagnosis: *

*Procedure/Service Requested:*

☐ CPT Code:

☐ HCPCS Code

Procedure/Service Description:

Number of visits: Duration:

Frequency of visits: Number of previous visits:

*Is supporting Clinical Information Attached?*

Yes No - Please summarize clinical information below

MCDTX_17_55673_PR Approved
Appendix J, Sample 3618 Form

Resident Transaction Notice

1. Medicaid Recipient No. 2. Social Security No. 3. Medicare or RR Retirement Claim No.

4. Name of Recipient (Last, First, Middle) - Enter first two letters of last name in far left positions.

5. Address (if known). Preadmission or Post Discharge Only

6. DADS Vendor No. 7. Contract No. 8. Service Group

9. NPI No.

10 - Transaction

☐ 1 - Admission From

☐ 2 - Discharged to

☐ 3 - Deceased

☐ 4 - Correction

If newly admitted from hospital enter date: __________________________

☐ 1 - Hospital 6. State Institution

☐ 2 - Nursing Facility 7. Hospice

☐ 3 - Community ICF-IID 8. Private Pay

☐ 4 - Medicare/SNF 5. Home

Date of physical admission to private pay: __________ Date of physical admission to private pay: __________

Discharge Type

☐ A - Return Not Anticipated

☐ B - Return Anticipated

☐ C - Prior To Completing Initial Assessment

☐ 3 - Deceased

☐ 4 - Correction

11. Date of Above Transaction

12. Comments

14. I certify that, to the best of my knowledge, the date in Item 11 (Date of Above Transaction) is for services provided, and the date is not included in the 100% Medicare Part A reimbursement time frame.

_____________________ Signature - Administrator  ______________________ Date

Appendix K, Sample 3619 Form

Medicare/Skilled Nursing Facility
Patient Transaction Notice

<table>
<thead>
<tr>
<th>1. Medicaid Recipient No.</th>
<th>2. Social Security No.</th>
<th>3. Medicare or RR Retirement Claim No.</th>
</tr>
</thead>
</table>

4. Name of Recipient (Last, First, Middle) - Enter first two letters of last name in far left positions.

5. Address (if known). Preadmission or Post Discharge Only

6. DADS Vendor No. | 7. Contract No. | 8. Service Group |

9. NPI No.

10 - Transaction

- [ ] 1 - Admission From
- [ ] 1 - Hospital
- [ ] 2 - Discharged to
- [ ] 2 - Nursing Facility
- [ ] 3 - Full Medicare Coverage
- [ ] 4 - Home
- [ ] 5 - Institution
- [ ] 6 - Other/Unknown

- [ ] 3 - Deceased
- [ ] 4 - Correction

11. Date of Above Transaction

12. Dates of Qualifying Stay - Enter an explanation in the *Comments* section if less than 20 days of "Qualifying Stay" are entered on this form. If additional sets of dates are needed, a second Form 3619 must be completed using the same "Date of above Transaction" in order to supply the additional set(s) of dates.

12.a. Dates of Qualifying Stay

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
</table>

12.b. Dates of Qualifying Stay

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
</table>

13. Comments

15. I certify that, to the best of my knowledge, the date in Item 11 (Date of Above Transaction) is for services provided, and the date is not included in the 100% Medicare Part A reimbursement time frame.


_________________________  _______________________
Signature - Administrator  Date
Appendix L, Sample UB-04 Claim Form
Appendix M, Sample CMS 1500 Claim Form

<table>
<thead>
<tr>
<th>HEALTH INSURANCE CLAIM FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDICARE</td>
</tr>
<tr>
<td>Medicare (Medicare ID)</td>
</tr>
<tr>
<td>1a. INSURED’S I.D. NUMBER</td>
</tr>
<tr>
<td>2. PATIENT’S NAME</td>
</tr>
<tr>
<td>3. PATIENT’S DATE OF BIRTH</td>
</tr>
<tr>
<td>4. PATIENT’S SEX</td>
</tr>
<tr>
<td>5. PATIENT’S ADDRESS</td>
</tr>
<tr>
<td>6. PATIENT’S RELATIONSHIP TO INSURED</td>
</tr>
<tr>
<td>7. INSURED’S I.D. NUMBER</td>
</tr>
<tr>
<td>8. INSURED’S NAME</td>
</tr>
<tr>
<td>9. OTHER INSURED’S NAME</td>
</tr>
<tr>
<td>10. OTHER INSURED’S policy OR GROUP NUMBER</td>
</tr>
<tr>
<td>11. INSURED’S policy GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>12. OTHER INSURED’S policy OR GROUP NUMBER</td>
</tr>
<tr>
<td>13. INSURED’S policy GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>14. INSURED’S policy GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>15. INSURED’S policy GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>16. INSURED’S policy GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>17. INSURED’S policy GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>18. INSURED’S policy GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>19. ADDITIONAL CLAIM INFORMATION</td>
</tr>
<tr>
<td>20. OUTSIDE LAB?</td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
</tr>
<tr>
<td>22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
</tr>
<tr>
<td>23. PRIOR AUTHORIZATION NUMBER</td>
</tr>
<tr>
<td>24. DATE(S) OF SERVICE</td>
</tr>
<tr>
<td>25. PLACE OF SERVICE</td>
</tr>
<tr>
<td>26. PROVIDER’S ACCOUNT NUMBER</td>
</tr>
<tr>
<td>27. TOTAL CHARGES</td>
</tr>
<tr>
<td>28. AMOUNT PAID</td>
</tr>
<tr>
<td>29. BILLING PROVIDER INFO &amp; PH #</td>
</tr>
</tbody>
</table>

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0038-1197 FORM 1500 (02-12)
Appendix N, Sample of Claims Appeal Form

Providers may fax Claims Appeal Form to 1-877-809-0783 or mail them to:
Cigna-HealthSpring STAR+PLUS
Appeals and Complaints Department
PO Box 211088
Bedford, TX 76095
Provider Services Phone Number: 1-877-653-0331

Cigna-HealthSpring® STAR+PLUS Appeals
Providers must request Claims Appeal within 120 days from the date of the Explanation of Payment (EOP).

Claims Appeal Form

Provider Information:
Provider Name:  
NPI:  TIN:  
Contact Person: Contact Number:

Claim Information:
Member Name: Medicaid ID:  
Number of Claims: Number of Pages Sent:

<table>
<thead>
<tr>
<th>Claim ID:</th>
<th>Date(s) of Service:</th>
<th>Authorization Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reason for Appeal/Denial:
☑ Denied for Non-covered Benefit ☐ Denied for No Auth
☑ Denied for Timely Filing ☐ Other

Explanation for Appeal:

Claim Information:
Member Name: Medicaid ID:  
Number of Claims: Number of Pages Sent:

<table>
<thead>
<tr>
<th>Claim ID:</th>
<th>Date(s) of Service:</th>
<th>Authorization Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reason for Appeal/Denial:
☑ Denied for Non-covered Benefit ☐ Denied for No Auth
☑ Denied for Timely Filing ☐ Other

Explanation for Appeal:

*Please attach any additional information and any supporting documentation.*

Indicate an authorization number, if applicable. Please be advised that corrected claims are not appeals.
Appendix O, Member Acknowledgement Statement

I understand that, in the opinion of ______[Provider Name]______, the services or items that I have requested to be provided to me on ___________________________ [Date] ____________ may not be covered under Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health-insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Patient Signature: ________________________________

Date: ________________________________
Appendix P, Private Pay Agreement

I understand that [Provider Name] is accepting me as a private pay patient for the period of [Enter Dates] and I will be responsible for paying any services I receive.

The provider will not file a claim to Medicaid or Cigna-HealthSpring for services provided to me during this period.

Patient Signature: ________________________________

Date: ________________________________