2014

PROVIDER MANUAL

Tennessee
Northern Georgia
Northern Mississippi
Eastern Arkansas

Cigna HealthSpring®

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MEMBER INFORMATION

Eligibility Verification

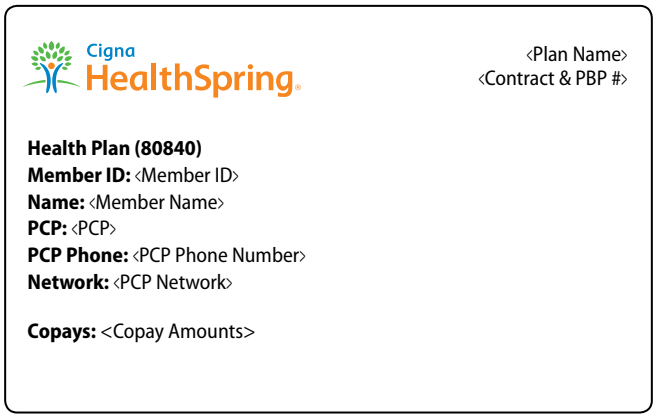
All participating providers are responsible for verifying a member's eligibility at each and every visit. Please note that membership data is subject to change. The Center for Medicare and Medicaid Service (CMS) retroactively terminates members for various reasons. When this occurs, the Cigna-HealthSpring claim recovery unit will request a refund from the provider. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question.

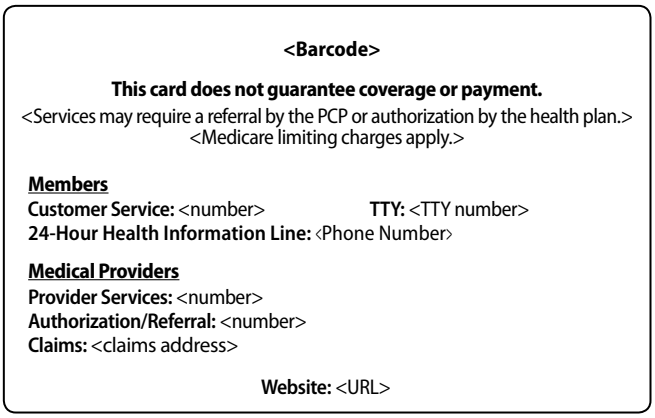
You can verify member eligibility the following ways:

- Call the Health Plan – You must call the Health Plan to verify eligibility when the member cannot present identification or does not appear on your monthly eligibility list. Please note, the Health Plan should have the most updated information, therefore, call the Health Plan for accuracy.
- HSConnect – The Cigna-HealthSpring web portal, HSConnect, allows our providers to verify member eligibility online through visiting **https://healthspring.hsconnectonline.com/HSConnect**
- Through our Interactive Voice Response (IVR) System at **1-800-230-6138**. The IVR System is available 24 hours a day, 7 days a week.
- Ask to see the Member's Identification Card – Each member is provided with an individual membership identification card. Noted on the ID card is the Member's identification number, plan code, name of PCP, co-payment, and effective date. Since changes do occur with eligibility, the card alone does not guarantee the member is eligible.
- Pursue additional proof of identification – Each PCP and specialist office is provided with a monthly Eligibility report upon request which lists new and current Cigna-HealthSpring members with their effective dates. Please be sure to refer to the most current month's eligibility listing.

2014 ID Cards

2014 MA ID CARD





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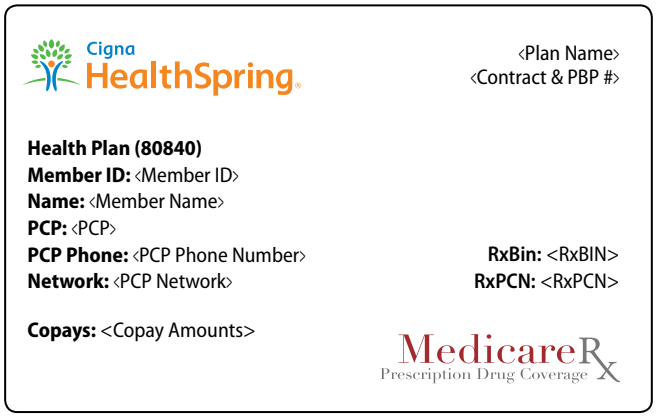
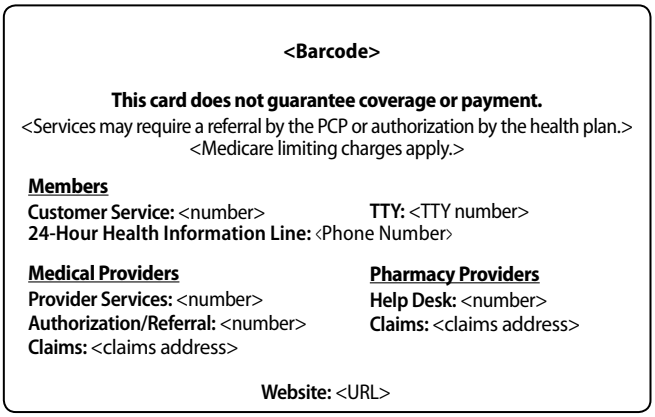




Maximum Out-of-Pocket (MOOP)

The Maximum Out-of-Pocket (MOOP) benefit is now a part of all Cigna-HealthSpring Benefit Plans. Members have a limit on the amount they will be required to pay out-of-pocket each year for medical services which are covered under Medicare Part A and Part B. Once this maximum out-of-pocket expense has been reached, the member no longer is responsible for any out-of-pocket expenses, including any cost shares, for the remainder of the year for covered Part A and Part B services (excluding the members' Medicare Part B premium and Cigna-HealthSpring plan premium).

Member Hold Harmless

Participating providers are prohibited from balance billing Cigna-HealthSpring 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 Participating Provider's Agreement. The provider is not, however, prohibited from collecting co-payments, co-insurances or deductibles for covered services in accordance with the terms of the applicable member's Benefit Plan.

Member Confidentiality

At Cigna-HealthSpring, we know our members' privacy is extremely important to them, and we respect their right to privacy when it comes to their personal information and health care. We are committed to protecting our members' personal information. Cigna-HealthSpring does not disclose member information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law. Because you are a valued provider to Cigna-HealthSpring, we want you to know the steps we have taken to protect the privacy of our members. This includes how we gather and use their personal information. Cigna-HealthSpring's privacy practices apply to all of Cigna-HealthSpring's past, present, and future members.

When a member joins a Cigna-HealthSpring Medicare Advantage plan, the member agrees to give Cigna-HealthSpring access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium. Access to PHI allows Cigna-HealthSpring to work with providers, like yourself, to decide whether a service is a Covered Service and pay your clean claims for Covered Services using the members' medical records. Medical records and claims are generally used to review treatment and to do quality assurance activities. It also allows Cigna-HealthSpring to look at how care is delivered and carry out programs to improve the quality of care Cigna-HealthSpring's members receive. This information also helps Cigna-HealthSpring manage the treatment of diseases to improve our members' quality of life.

Cigna-HealthSpring's members have additional rights over their health information. They have the right to:

Send Cigna-HealthSpring a written request to see or get a copy of information about them, or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer Cigna-HealthSpring's member to the source of the information.

Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.

Receive an accounting of Cigna-HealthSpring's disclosures of their medical information, except when those disclosures are for treatment, payment or health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect member PHI. To discuss any breaches of the privacy of our members, please contact our HIPAA Privacy Officer at **1-615-236-6157**.

Member Rights and Responsibilities

Cigna-HealthSpring members have the following rights: The right to be treated with dignity and respect

Members have the right to be treated with dignity, respect, and fairness at all times. Cigna-HealthSpring must obey laws against discrimination that protect members from unfair treatment. These laws say that Cigna-HealthSpring cannot discriminate against members (treat members unfairly) because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If members need help with communication,

such as help from a language interpreter, they should be directed to call Member Services. Member Services can also help members in filing complaints about access to facilities (such as wheel chair access). Members can also call the Office for Civil Rights at **1-800-368-1019** or TTY/TDD **1-800-537-7697**, or the Office for Civil Rights in their area for assistance.

The right to the privacy of medical records and personal health information

There are federal and state laws that protect the privacy of member medical records and personal health information. Cigna-HealthSpring keeps members' personal health information private as required under these laws. Any personal information that a member gives Cigna-HealthSpring is protected. Cigna-HealthSpring staff will make sure that unauthorized people do not see or change member records. Generally, we will get written permission from the member (or from someone the member has given legal authority to make decisions on their behalf) before we can give member health information to anyone who is not providing the member's medical care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect member privacy give them rights related to getting information and controlling how their health information is used. Cigna-HealthSpring is required to provide members with a notice that tells them about these rights and explains how Cigna-HealthSpring protects the privacy of their health information. For example, members have the right to look at their medical records, and to get copies of the records (there may be a fee charged for making copies). Members also have the right to ask plan providers to make additions or corrections to their medical records (if members ask plan providers to do this, they will review member requests and figure out whether the changes are appropriate). Members have the right to know how their health information has been given out and used for routine and non-routine purposes. If members have questions or concerns about privacy of their personal information and medical records, they should be directed to call Member Services. Cigna-HealthSpring will release a member's information, including prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The right to see participating providers, get covered services, and get prescriptions filled within a reasonable period of time

Members will get most or all of their health care from participating providers, that is, from doctors and other health providers who are part of Cigna-HealthSpring. Members have the right to choose a participating provider (Cigna-HealthSpring will work with members to ensure they find physicians who are accepting new patients). Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to timely access to their prescriptions at any network pharmacy. "Timely access" means that members can get appointments and services within a reasonable amount of time. The Evidence of Coverage explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know treatment choices and participate in decisions about their health care

Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their health care. Cigna-HealthSpring providers must explain things in a way that members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition including all appropriate and medically necessary treatment options, no matter what their cost or whether they are covered by Cigna-HealthSpring. This includes the right to know about the different Medication Management Treatment Programs Cigna-HealthSpring offers and those in which members may participate. Members have the right to be told about any risks involved in their care. Members must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice of refusing experimental treatments.

Members have the right to receive a detailed explanation from Cigna-HealthSpring if they believe that a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. "Initial decisions" are discussed in the members' Evidence of Coverage.

Members have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. This also includes the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to use advance directives (such as a living will or a power of attorney)

Members have the right to ask someone such as a family member or friend to help them with decisions

about their health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If a member wants to, he/she can use a special form to give someone they trust the legal authority to make decisions for them if they ever become unable to make decisions for themselves. Members also have the right to give their doctors written instructions about how they want them to handle their medical care if they become unable to make decisions for themselves. The legal documents that members can use to give their directions in advance of these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living wills"** and **"powers of attorney for health care"** are examples of advance directives.

If members decide that they want to have an advance directive, there are several ways to get this type of legal form. Members can get a form from their lawyer, from a social worker, from Cigna-HealthSpring, or from some office supply stores. Members can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where they get this form, keep in mind that it is a legal document. Members should consider having a lawyer help them prepare it. It is important to sign this form and keep a copy at home. Members should give a copy of the form to their doctor and to the person they name on the form as the one to make decisions for them if they can't. Members may want to give copies to close friends or family members as well.

If members know ahead of time that they are going to be hospitalized and they have signed an advance directive, they should take a copy with them to the hospital. If members are admitted to the hospital, the hospital will ask them whether they have signed an advance directive form and whether they have it with them. If members have not signed an advance directive form or does not have a copy available during admission, the hospital has forms available and will ask if the member wants to sign one.

Remember, **it is a member's choice** whether he/she wants to fill out an advance directive (including whether they want to sign one if they are in the hospital). According to law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive. If members have signed an advance directive and they believe that a doctor or hospital has not followed the instructions in it, Members may file a complaint with their State Board of Medicine or appropriate state agency (this information can be found in the member's Evidence of Coverage).

The right to make complaints

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. Members or an appointed/authorized representative may file "Appeals," "grievances," concerns and coverage determinations. If members make a complaint or file an appeal or coverage determination, Cigna-HealthSpring must treat them fairly (i.e., not discriminate against them) because they made a complaint or filed an appeal or coverage determination. To obtain information relative to appeals, grievances, concerns and/or coverage determinations, members should be directed to call Member Services.

The right to get information about their health care coverage and cost

The Evidence of Coverage tells members what medical services are covered and what they have to pay. If they need more information, they should be directed to call Member Services. Members have the right to an explanation from Cigna-HealthSpring about any bills they may get for services not covered by Cigna-HealthSpring. Cigna-HealthSpring must tell members in writing why Cigna-HealthSpring will not pay for or allow them to get a service and how they can file an appeal to ask Cigna-HealthSpring to change this decision. Staff should inform members on how to file an appeal, if asked, and should direct members to review their Evidence of Coverage for more information about filing an appeal.

The right to get information about Cigna-HealthSpring, plan providers, drug coverage, and costs

Members have the right to get information about the Cigna-HealthSpring plans and operations. This includes information about our financial condition, about the services we provide, and about our health care providers and their qualifications. Members have the right to find out from us how we pay our doctors. To get any of this information, Members should be directed to call Member Services. Members have the right to get information from us about their Part D prescription coverage. This includes information about our financial condition and about our network pharmacies. To get any of this information, staff should direct members to call Member Services.

The right to get more information about members' rights

Members have the right to receive information about their rights and responsibilities. If members have questions or concerns about their rights and protections, they should be directed to call Member Services. Members can also get free help and information from their State Health Insurance Assistance Program

(SHIP). In addition, the Medicare program has written a booklet called Members Medicare Rights and Protections. To get a free copy, members should be directed to call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call 1-877-486-2048. Members can call 24 hours a day, 7 days a week. Or, members can visit **www.medicare.gov** on the web to order this booklet or print it directly from their computer.

The right to take action if a member thinks they have been treated unfairly or their rights are not being respected

- If members think they have been treated unfairly or their rights have not been respected, there are options for what they can do.
- If members think they have been treated unfairly due to their race, color, national origin, disability, age, or religion, we must encourage them to let us know immediately. They can also call the Office for Civil Rights in their area.
- For any other kind of concern or problem related to their Medicare rights and protections described in this section, members should be encouraged to call Member Services. Members can also get help from their State Health Insurance Assistance Program (SHIP).

Cigna-HealthSpring members have the following responsibilities:

- Along with certain rights, there are also responsibilities associated with being a member of Cigna-HealthSpring. Members are responsible for the following:
- To become familiar with their Cigna-HealthSpring coverage and the rules they must follow to get care as a member. Members can use their Cigna-HealthSpring Evidence of Coverage and other information that we provide them to learn about their coverage, what we have to pay, and the rules they need to follow. Members should always be encouraged to call Member Services if they have any questions or complaints.
- To advise Cigna-HealthSpring if they have other insurance coverage.
- To notify providers when seeking care (unless it is an emergency) that they are enrolled with Cigna-HealthSpring and present their plan enrollment card to the provider.
- To give their doctors and other providers the information they need to provide care for them and to follow the treatment plans and instructions that they and their doctors agree upon. Members must be encouraged to ask questions of their doctors and other providers whenever the member has them.
- To act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices.
- To pay their plan premiums and any co-payments or coinsurances they may have for the Covered Services they receive. Members must also meet their other financial responsibilities that are described in their Evidence of Coverage.
- To let Cigna-HealthSpring know if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage, and/or Cigna-HealthSpring operations.
- To notify Cigna-HealthSpring Member Services and their providers of any address and/or phone number changes as soon as possible.
- To use their Cigna-HealthSpring plan only to access services, medications and other benefits for themselves.

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right is 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 our own policies and procedures, Cigna-HealthSpring requires all participating providers to have a process in place pursuant to the intent of the Patient Self Determination Act.

All providers contracted directly or indirectly with Cigna-HealthSpring may be informed by the member that the member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record.

If the Primary Care Physician (PCP) and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he/she must advise the member and Cigna-HealthSpring. Cigna-HealthSpring and the PCP and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in The Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience.

To ensure providers maintain the required processes to Advance Directives, Cigna-HealthSpring

conducts periodic patient medical record reviews to confirm that required documentation exists.

Benefits and Services

All Cigna-HealthSpring members receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, Cigna-HealthSpring makes available to each participating Primary Care Physicians a list of their active members. Along with the member's demographic information, the list includes the name of the Plan in which the member enrolled. Please be aware that recently-terminated members may appear on the list. (See "Eligibility Verification" section of this manual).

Cigna-HealthSpring encourages its members to call their Primary Care Physician to schedule appointments. However, if a Cigna-HealthSpring member calls or comes to your office for an unscheduled non-emergent appointment, please attempt to accommodate the member and explain to them your office policy regarding appointments. If this problem persists, please contact Cigna-HealthSpring.

Emergency Services and Care After Hours

Emergency Services

An emergency is defined by Cigna-HealthSpring as the sudden onset of a medical condition with acute symptoms. A member may reasonably believe that the lack of immediate medical attention could results in:

- Permanently placing the member's health in jeopardy
- Causing serious impairments to body functions
- Causing serious or permanent dysfunction of any body organ or part

In the event of a perceived emergency, members have been instructed to first contact their Primary Care Physician for medical advice. However, if the situation is of such a nature that it is life threatening, members have been instructed to go immediately to the nearest emergency room facility. Members who are unable to contact their PCP prior to receiving emergency treatment have been instructed to contact their PCP as soon as is medically possible or within forty-eight (48) hours after receiving care. The PCP will be responsible for providing and arranging any necessary follow-up services.

For emergency services within the service area, the PCP is responsible for providing, directing, or authorizing a member's emergency care. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to assist members needing emergency services. The hospital may attempt to contact the PCP for direction. Members have a co-payment responsibility for outpatient emergency visits unless an admission results.

For emergency services outside the service area, Cigna-HealthSpring will pay reasonable charges for emergency services received from non-participating providers if a member is injured or becomes ill while temporarily outside the service area. Members may be responsible for a co-payment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

Urgent Services

- Urgent Care services are for the treatment of symptoms that are non-life threatening but that require immediate attention. The member must first attempt to receive care from his/her PCP. Treatment at a participating Urgent Care Center will be covered by Cigna-HealthSpring without a referral.
- Continue or Follow-up Treatment
- Continuing or follow-up treatment, except by the PCP, whether in or out of service area, is not covered by Cigna-HealthSpring unless specifically authorized or approved by Cigna-HealthSpring. Payment for covered benefits outside the service area is limited to medically necessary treatment required before the member can reasonably be transported to a participating hospital or returned to the care of the PCP.

Excluded Services

In addition to any exclusion or limitations described in the members' EOC, the following items and services are not covered under the Original Medicare Plan or by Cigna-HealthSpring:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our plan and the Original Medicare Plan to not be generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary or covered under the Original Medicare Plan
- Private room in a hospital, unless medically necessary
- Private duty nurses

- Personal convenience items, such as a telephone or television in a member's room at a hospital or skilled nursing facility
- Nursing care on a full-time basis in a member's home
- Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating, and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Homemaker services
- Charges imposed by immediate relatives or members of the member's household
- Meals delivered to the member's home
- Elective or voluntary enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance unless medically necessary
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care (i.e. cleanings, fillings, or dentures) or other dental services unless otherwise specified in the EOC. However, non-routine dental services received at a hospital may be covered.
- Chiropractic care is generally not covered under the plan with the exception of manual manipulation of the spine and is limited according to Medicare guidelines.
- Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines
- Orthopedic shoes unless they are part of a leg brace and included in the cost of the brace. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Supportive devices for the feet. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC
- Eyeglasses, with the exception of after cataract surgery, routine eye examinations, racial keratotomy, LASIK surgery, vision therapy and other low vision aids and services unless otherwise specified in the EOC
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy unless otherwise included in the member's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures, sex change operations, and non-prescription contraceptive supplies
- Acupuncture
- Naturopath services
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency situations received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under the plan, the plan will reimburse veterans for the difference. Members are still responsible for our plan cost-sharing amount.

Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Grievance and Appeal Process

All telephone complaints received by Cigna-HealthSpring's Medicare Advantage Customer Service department will be resolved on an informal basis, except for complaints that involve "appealable" issues. These appealable issues will be placed in either the expedited or standard appeals process. In situations where a member remains dissatisfied with the informal resolution, the member must submit in writing a request for reconsideration of the informal resolution. All other written letter of complaint received by Cigna-HealthSpring will be logged in our tracking system and automatically placed within either the appeal or grievance process, whichever is appropriate.

Members of Cigna-HealthSpring have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

- Complaints about services in an optional Supplementary Benefit package
- Complaints regarding issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns
- Involuntary disenrollment situations
- Complaints concerning the quality of services a member receives

Members of Cigna-HealthSpring have the right to appeal any decision about Cigna-HealthSpring's failure to provide what they believe are benefits contained in the basic benefit package. These include:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by Cigna-HealthSpring
- Services they have not received, but believe are the responsibility of Cigna-HealthSpring to pay for
- A reduction in or termination of service a member feels are medically necessary

In addition, a member may appeal any decision to discharge them from the hospital. In this case, a notice will be given to the member with information about how to appeal and will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review.

Please refer to the Cigna-HealthSpring Evidence of Coverage (EOC) for additional information.

Dual Eligible Members

Many of your patients may have Cigna-HealthSpring as their primary insurance payer and Medicaid as their secondary payer. This will require you to coordinate the benefits of these "dual eligible" Cigna-HealthSpring Members by determining whether the member should be billed for the deductibles and co-payments, or coinsurances associated with their benefit plan. Providers may not assess a QMB (Qualified Medicare Beneficiary) or QMB-Plus for Cigna-HealthSpring co-payments, coinsurances, and/or deductibles.

Providers will accept as payment in full Cigna-HealthSpring's payment and will not seek additional payment from the State or dual eligible members. Additional information concerning Medicaid provider participation is available at: **www.cignahealthspring.com**.

A member's level of Medicaid eligibility can change due to their medical and financial needs. Cigna-HealthSpring encourages you to verify members' Medicaid eligibility when rendering services which will help you determine if the member owes a deductible or co-pay.

Medicaid eligibility can be obtained by using the Medicaid telephonic Eligibility Verification System. If you do not have access to the system, please contact your State Medicaid provider for additional information.

Please note, each state varies in their decision to cover the cost-share for populations beyond QMB and QMB+.

Cigna-HealthSpring Cost-Sharing Chart

Patient's Medicaid Plan	Patient's Liability Patient Owes Deductibles & Copayments associated with Benefit Plan	Medicaid provides benefits Patient not liable for Deductibles & Copayments associated with Benefit Plan
Medicaid (FBDE)	No	Yes
QMB Only	No	Yes
QMB+	No	Yes
SLMB	Yes	No
SLMB+	Yes	No
QI-1	Yes	No
QDWI	Yes	No

Medicaid Coverage Groups

Full Benefit Dual Eligibles (FBDE)

An individual who is eligible for Medicaid either categorically or through optional coverage groups such as medically-needy or special income levels for institutionalized or home and community-based waivers, but who does not meet the income or resource criteria for QMB or SLMB.

Qualified Medicare Beneficiary (QMB Only)

A "QMB" is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance, and co-payments (except for Part D). QMBs who do not qualify for any additional Medicaid Benefits are called "QMB Only". Providers may not assess a QMB for Cigna-HealthSpring deductibles, co-payments, or coinsurances.

Qualified Medicare Beneficiary Plus (QMB+)

An individual who meets standards for QMB eligibility and also meets criteria for full Medicaid benefits in the State. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or through spending down excess income to the Medically Needy level.

Specified Low-income Medicare Beneficiary (SLMB Only)

A "SLMB" is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than 120% FPL, and whose resources do not exceed twice the SSI limit. The only Medicaid benefit for which a SLMB is eligible is payment of Medicare Part B premiums. SLMBs who do not qualify for any additional Medicaid benefits are called "SLMB Only".

Specified Low-Income Medicare Beneficiary Plus (SLMB+)

An individual who meets the standards for SLMB eligibility, but who also meets the criteria for full State Medicaid benefits. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits. These individuals often qualify for Medicaid by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.

Qualifying Individual (QI)

A "QI" is an individual who is entitled to Part A, has income that is at least 120% FPL but less than 135% FPL, resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. A QI is similar to a SLMB in that the only benefit available is Medicaid payment of the Medicare Part B premium; however, expenditures for QIs are 100% federally funded and the total expenditures are limited by statute.

Other Full Benefit Dual Eligibles (FBDE)

An individual who is eligible for Medicaid either categorically or through optional coverage groups such as medically-needy or special income levels for institutionalized or home and community-based waivers, but who does not meet the income or resource criteria for QMB or SLMB.

Qualified Disabled and Working Individual (QDWI)

A QDWI is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. QDWIs are eligible only for Medicaid payment of Part A premiums.

The State of Tennessee Bureau of TennCare ± Nursing Facility Diversion Program

Background

On July 15, 2008, the PL 110-275 Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was signed into law and amended titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

As mentioned above, the "other purposes" portion of the law includes revisions relating to specialized Medicare Advantage plans for special needs individuals. MIPPA requires Special Needs Plans (SNPs) to contract with their state Medicaid agencies to provide benefits, or arrange for benefits to be provided. Cigna-HealthSpring holds a contract with the State of Tennessee Bureau of TennCare to coordinate care and to provide data to the State on these special needs individuals.

This contract covers Cigna-HealthSpring Members qualifying for both Medicare and Medicaid full benefits(dually eligible) and includes the following Medicaid coverage groups ; FBDE, QMB+, and SLMB+. Cigna-HealthSpring offers its special needs plan, TotalCare, in one or more counties in Tennessee.

Requirement

One of the State's requirements is that network providers work with dually eligible members' TennCare MCOs in the implementation of its nursing facility diversion program, including:

1. Communication between the provider and the TennCare MCO of any FBDE member served by the provider;
2. Identification of and referral to the TennCare MCO of potential candidates for nursing facility diversion; and
3. Delivery of services in a manner that will help prevent/delay nursing facility placement and sustain community living, when appropriate.

Nursing Facility Diversion Program

- MCOs have developed nursing facility diversion plans specific to their organization
- Target groups include at a minimum:
  - Persons waiting for admission to nursing facility
  - CHOICES members living at home or in a Community Based Residential Alternative (CBRA) who have had a negative change in circumstances or health and are requesting nursing facility services
  - Any member who has been admitted to an inpatient hospital or rehabilitation center who is not a nursing facility resident
  - Any member who is admitted for a short term stay to nursing facility regardless of payer source
- Nursing Facility Diversion process includes a detailed description of how the MCO will:
  - Work with providers (including hospitals regarding notice of admission and discharge planning)
  - Ensure appropriate communication among providers and between providers and the MCO
  - Train key MCO and provider staff
  - Identify members (early) who may be candidates for diversion (both CHOICES and non-CHOICES members)

- Conduct follow-up activities to help sustain community living

What this means for you:

1. If the TennCare Medicaid Managed Care Organization contacts you, please respond in a timely manner and engage in discussion as appropriate.
2. Be aware of TennCare's Nursing Facility Diversion program. Cigna-HealthSpring is actively identifying and referring Cigna-HealthSpring Members for the program.
3. Deliver services in a timely manner.

If you identify a TotalCare dually eligible member who may benefit from TennCare's nursing facility diversion program, please contact:

- Cigna-HealthSpring's TennCare Request Intake Coordinator at **1-888-615-2709**, or E-mail **totalcare@Cigna-HealthSpring.com**
- Reference/Subject : TennCare Coordination Request for Nursing Facility Diversion program. We'll do the rest!

Continuity of Care

Cigna-HealthSpring's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services.

When a practitioner leaves Cigna-HealthSpring's network and a member is in an active course of treatment, our Health Services staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time. In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. Members in their second or third trimester of pregnancy have access to the exiting provider through the postpartum period.

If the Plan terminates a participating provider, Cigna-HealthSpring will work to transition a member into care with a Participating Physician or other provider within Cigna-HealthSpring's network. Cigna-HealthSpring is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Cigna-HealthSpring also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in Cigna-HealthSpring's network. Under these circumstances, Cigna-HealthSpring will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment. Cigna-HealthSpring will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care.

PROVIDER INFORMATION

Providers Designated as Primary Care Physicians (PCPs)

Cigna-HealthSpring recognizes Family Medicine, General Practice, Geriatric Medicine, and Internal Medicine physicians as Primary Care Physicians (PCPs).

Cigna-HealthSpring may recognize Infectious Disease Physicians as PCPs for members who may require a specialized physician to manage their specific health care needs.

All contracted credentialed providers participating with Cigna-HealthSpring are listed in the region-appropriate Provider Directory, which is provided to members and made available to the public.

The Role Of The Primary Care Physician (PCP)

Each Cigna-HealthSpring member must select a Cigna-HealthSpring Participating Primary Care Physician (PCP) at the time of enrollment. The PCP is responsible for managing all the health care needs of a Cigna-HealthSpring member as follows:

- Manage the health care needs of Cigna-HealthSpring members who have chosen the physician as their PCP;
- Ensure that members receive treatment as frequently as is necessary based on the member's condition;
- Develop an individual treatment plan for each member;
- Submit accurately and timely claims and encounter information for clinical care coordination;
- Comply with Cigna-HealthSpring's pre-authorization and referral procedures;
- Refer members to appropriate Cigna-HealthSpring participating providers;
- Comply with Cigna-HealthSpring's Quality Management and Utilization Management programs;
- Participate in Cigna-HealthSpring's 360 Assessment Program;
- Use appropriate designated ancillary services;

- Comply with emergency care procedures;
- Comply with Cigna-HealthSpring access and availability standards as outlined in this manual, including after-hours care;
- Bill Cigna-HealthSpring on the CMS 1500 claim form or electronically in accordance with Cigna-HealthSpring billing procedures;
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record;
- Comply with Preventive Screening and Clinical Guidelines;
- Adhere to Cigna-HealthSpring's medical record standards as outlined in this manual.

The Role of the Specialist Physician

Each Cigna-HealthSpring member is entitled to see a Specialist Physician for certain services required for treatment of a given health condition. The Specialist Physician is responsible for managing all the health care needs of a Cigna-HealthSpring member as follows:

- Provide specialty health care services to members as needed;
- Collaborate with the member's Cigna-HealthSpring Primary Care Physician to enhance continuity of health care and appropriate treatment;
- Provide consultative and follow-up reports to the referring physician in a timely manner;
- Comply with access and availability standards as outlined in this manual including after-hours care;
- Comply with Cigna-HealthSpring's pre-authorization and referral process;
- Comply with Cigna-HealthSpring's Quality Management and Utilization Management programs;
- Bill Cigna-HealthSpring on the CMS 1500 claim form in accordance with Cigna-HealthSpring's billing procedures;
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record;
- Refer members to appropriate Cigna-HealthSpring participating providers;
- Submit encounter information to Cigna-HealthSpring accurately and timely;
- Adhere to Cigna-HealthSpring's medical record standards as outlined in this manual.

Administrative, Medical and/or Reimbursement Policy Changes

From time to time, Cigna-HealthSpring may amend, alter, or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards, and modification of Covered Services. Specific Cigna-HealthSpring policies and procedures may be obtained by calling our Provider Services Department at **1-800-230-6138**

Cigna-HealthSpring will communicate changes to the Provider Manual through the use of a variety of methods including but not limited to:

- Annual Provider Manual Updates
- Letter
- Facsimile
- Email
- Provider Newsletters

Providers are responsible for the review and inclusion of policy updates in the Provider Manual and for complying with these changes upon receipt of these notices.

Communication Among Providers

- The PCP should provide the Specialist Physician with relevant clinical information regarding the member's care.
- The Specialist Physician must provide the PCP with information about his/her visit with the member in a timely manner.
- The PCP must document in the member's medical record his/her review of any reports, labs, or diagnostic tests received from a Specialist Physician.

Provider Marketing Guidelines

The below is a general guideline to assist Cigna-HealthSpring providers who have contracted with multiple Medicare Advantage plans and is accepting Medicare FFS patients in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to 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.

Provider Can:

- Mail/call their patient panel to invite patients to general Cigna-HealthSpring sponsored educational events to learn about the Medicare and/or Medicare Advantage 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 Medicare Advantage plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior CMS approval and the agreement of all plans listed.
- Notify patients in a letter of a decision to participate in a Cigna-HealthSpring sponsored programs.
- Utilize a physican/patient newsletter to communicate information to patients on a variety of subjects. This newsletter can have a Cigna-HealthSpring corner to advise 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 marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Display and distribute in provider offices Cigna-HealthSpring MA and MAPD marketing materials, excluding application forms. The office must display or offer to display materials for all participating MA plans.
- Notify patients of a physician's decision to participate exclusively with Cigna-HealthSpring for Medicare Advantage or to close panel to original Medicare FFS 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.

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, as 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 a health plan.
- Advertise using Cigna-HealthSpring's name without Cigna-HealthSpring's prior consent and potentially CMS approval depending upon the content of the advertisement.

Member Assignment To New PCP

Cigna-HealthSpring Primary Care Physicians have a limited right to request a member be assigned to a new Primary Care Physician. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits
- 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.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- 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 managed care organization to coordinate treatment of the underlying medical condition).

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied through reasonable efforts, and the PCP feels the relationship has been irreparably harmed, the PCP should complete the Member Transfer Request form and submit it to Cigna-HealthSpring.

Cigna-HealthSpring will research the concern and decide if the situation warrants requesting a new PCP assignment. If so, Cigna-HealthSpring will document all actions taken by the provider and Cigna-HealthSpring to cure the situation. This may include member education and counseling. A Cigna-HealthSpring PCP 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.

Procedure

- Once Cigna-HealthSpring has reviewed the PCP's request and determined that the physician/ patient relationship has been irreparably harmed, the member will receive a minimum of thirty (30) days notice that the physician/patient relationship will be ending. Notification must be in writing, by certified mail and Cigna-HealthSpring must be copied on the letter sent to the patient.
- The physician will continue to provide care to the member during the thirty (30) day period or until the member selects or is assigned to another physician. Cigna-HealthSpring will assist the member in establishing a relationship with another physician.
- The physician will transfer, at no cost, a copy of the medical records of the member to the new PCP and will cooperate with the member's new PCP in regards to transitioning care and providing information regarding the member's care needs.

A member may also request a change in PCP for any reason. The PCP change that is requested by the member will be effective the first (1st) of the month following the receipt of the request, unless circumstances require an immediate change.

Provider Participation

Providers must be contracted with and credentialed by Cigna-HealthSpring according to the following guidelines:

Provider	Status	Action
New to plan and not previously credentialed	Practicing in a solo practice	Requires a signed contract and initial credentialing
New to plan and not previously credentialed	Joining a participating group practice	Requires initial credentialing
Already participating and credentialed	Leaving a group practice to begin a solo practice	Does not require credentialing; however a new contract is required and the previous group practice affiliation is terminated
Already participating and credentialed	Leaving a participating group practice to join another participating group practice	Does not require credentialing yet the group practice affiliation will be amended
Already participating and credentialed	Leaving a participating group practice to join a non-participating group practice	The Provider's participation is terminated unless the non-participating group signs a contract with Bravo Health/Cigna-HealthSpring. Credentialing is still valid until re-credentialing due date

Plan Notification Requirements For Providers

Participating providers must provide written notice to Cigna-HealthSpring no less than 60 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

The following is a list of changes that must be reported to Cigna-HealthSpring by contacting your Network Operation Representative or Customer Service:

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

- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations

By providing this information in a timely manner, you will ensure that your practice is listed correctly in the provider directory. Please note, failure to provide up to date and correct information regarding demographic information regarding your practice and the physicians that participate may result in the denial of claims for you and your physicians.

Closing Patient Panels

When a Participating Primary Care Physician elects to stop accepting new patients, the provider's patient panel is considered closed. If a Participating Primary Care Physician closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against Cigna-HealthSpring members by closing their patient panels for Cigna-HealthSpring members only, nor may they discriminate among Cigna-HealthSpring members by closing their panel to certain product lines. Providers who decide that they will no longer accept any new patients must notify Cigna-HealthSpring's Network Management Department, in writing, at least 30 days before the date on which the patient panel will be closed or the time frame specified in your contract.

Medical Record Standards

Cigna-HealthSpring requires the following items in member medical records:

- Identifying information of the member
- Identification of all providers participating in the member's care and information on services furnished by these providers
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses, and treatment plans
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
- Information on advanced directives
- Past medical history, physical examinations, necessary treatments, and possible risk factors for the member relevant to the particular treatment.

Access and Availability Standards For Providers

A Primary Care Physician (PCP) must have their primary office open to receive Cigna-HealthSpring members five (5) days and for at least 20 hours per week. The PCP must ensure that coverage is available 24 hours a day, seven days a week. PCP offices must be able to schedule appointments for Cigna-HealthSpring members at least two (2) months in advance of the appointment. A PCP must arrange for coverage during absences with another Cigna-HealthSpring participating provider in an appropriate specialty which is documented on the Provider Application and agreed upon in the Provider Agreement.

Primary Care Access Standards

Appointment Type	Access Standard
Urgent	Immediately
Non-Urgent/Non-Emergent	Within one (1) week
Routine and Preventive	Within 30 Business Days
On-Call Response (After Hours)	Within 30 minutes for emergency
Waiting Time in Office	30 minutes or less

Specialist Access Standards

Appointment Type	Access Standard
Urgent	Immediately
Non-Urgent/Non-Emergent	Within one (1) week
Elective	Within 30 days
High Index of Suspicion of Malignancy	Less than seven (7) days

Behavioral Health Access Standards

Appointment Type	Access Standard
Emergency	Within 6 hours of the referral
Urgent/Symptomatic	Within 48 hours of the referral
Routine	Within ten (10) business days of the referral*

*Revised 03/2013

After-Hours Access Standards

All participating providers must return telephone calls related to medical issues. Emergency calls must be returned within 30 minutes of the receipt of the telephone call. Non-emergency calls should be returned within a 24-hour time period. A reliable 24 hours a day/7 days a week answering service with a beeper or paging system and on-call coverage arranged with another participating provider of the same specialty is preferred.

Physician Rights and Responsibilities

Physician Rights:

- Cigna-HealthSpring encourages your feedback and suggestions on how service may be improved within the organization.
- If an acceptable patient-physician relationship cannot be established with a Cigna-HealthSpring member who has selected you as his/her primary care physician, you may request that Cigna-HealthSpring have that member removed from your care.
- You may appeal any claims submissions in which you feel are not paid according to medical policy or in keeping with the level of care rendered.
- You may request to discuss any referral request with the Medical Director or Chief Medical Officer after various times in the review process, before a decision is rendered or after a decision is rendered.
- Physician Responsibilities:
- You have agreed to treat Cigna-HealthSpring members the same as all other patients in your practice, regardless of the type or amount of reimbursement.
- Specialists must provide specialty services listed on the referral from the Primary Care Physician.
- Primary Care Physicians shall use best efforts to provide patient care to new members within four (4) months of enrollment with Cigna-HealthSpring.
- Primary Care Physicians shall use best efforts to provide follow-up patient care to members that have been in the hospital setting within ten (10) days of hospital discharge.
- Primary Care Physicians are responsible for the coordination of routine preventive care along with any ancillary services that need to be rendered with authorization.
- All providers are required to code to the highest level of specificity necessary to fully describe a member's acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.
- Specialists must provide specialty services up on referral from the Primary Care Physician and work closely with the referring physician regarding the treatment the member is to receive. Specialists must also provide continuous 24 hour, 7 days a week access to care for Cigna-HealthSpring members.
- Specialists are required to coordinate the referral process (i.e. obtain authorizations) for the further care that they recommend. This responsibility does not revert back to the Primary Care Physician while the care of the member is under the direction of the Specialist.
- In the event you are temporarily unavailable or unable to provide patient care or referral services to a Cigna-HealthSpring member, you must arrange for another physician to provide such services on your behalf. This coverage cannot be provided by an Emergency Room.
- You have agreed to treat Cigna-HealthSpring members the same as all other patients in your practice, regardless of the type of amount of reimbursement.
- You have agreed to provide continuing care to participating members.
- You have agreed to utilize Cigna-HealthSpring's participating physicians/facilities when services are available and can meet your patient's needs. Approval prior to referring outside of the contracted network of providers may be required.
- You have agreed to participate in Cigna-HealthSpring's peer review activities as they relate to the Quality Management/ Utilization Review program.
- You may not balance bill a member for providing services that are covered by Cigna-HealthSpring. This excludes the collection of standard co-pays. You may bill a member for a procedure that is not a covered benefit if you have followed the appropriate procedures outlined in the Claims section of this manual.
- All claims must be received within the timeframe specified in your contract.

Provision of Health Care Services

Participating providers shall provide health care services to all members, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment or any other bases deemed unlawful under federal, state, or local law.

Delegation

Delegation is a formal process by which Cigna-HealthSpring enters into a written contract with an entity to provide administrative or health care services on behalf of a Medicare eligible member. A function may be fully or partially delegated.

Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated. The decision of what function

may be considered for delegation is determined by the type of participation agreement a provider group has with Cigna-HealthSpring, as well as the ability of the provider group to perform the function. Contact the local Cigna-HealthSpring provider representative for detailed information on delegation.

Although Cigna-HealthSpring can delegate the authority to perform a function, it cannot delegate the responsibility.

Delegated providers must comply with the responsibilities outlined in the Delegated Services Agreement.

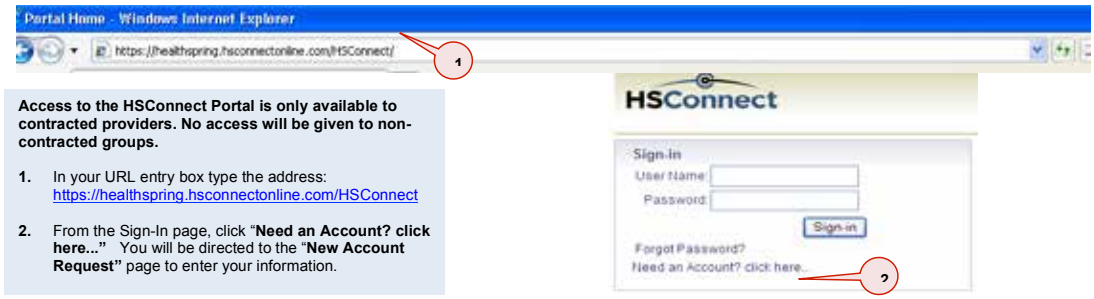
HS CONNECT

Experience the Ease of HSConnect

- View Member Eligibility
- Create Referrals
- Create Precertifications
- Search Authorizations
- Search Claims

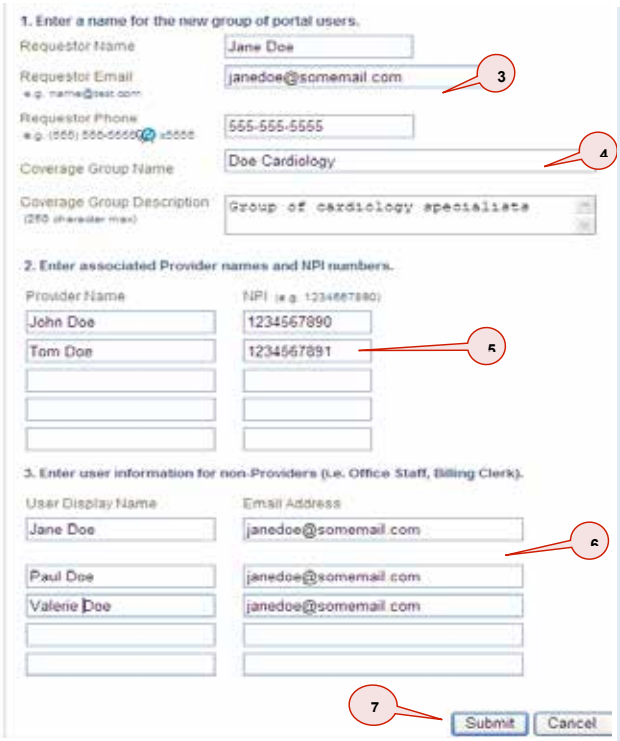
HSConnect

Quick Reference Card: Register for HSConnect Access – Provider Register



Access to the HSConnect Portal is only available to contracted providers. No access will be given to non-contracted groups.

1. In your URL entry box type the address: https://healthspring.hsconnectonline.com/HSConnect
2. From the Sign-In page, click "**Need an Account? click here...**" You will be directed to the "**New Account Request**" page to enter your information.



3. Enter the first and last name of the person requesting the account, practice Phone number, as well as the email address.

   Note: Failure to provide valid information could delay access to the portal.

4. Next, enter the coverage group name & description.
   Coverage Group Name - Operating name and/or name used with general public.
   Coverage Group Description - The provider type of the requesting group. Enter practitioner, facility or ancillary.

5. You must enter the individual NPI's for each provider that you need access for. If you have more than 5 providers, submit an additional request, or email : HSC_Account_Request@healthspring.com

6. Enter the ***first and last names*** for each user needing access, along with a valid email address for each user. If you have more than 5 users, submit an additional request, or email: HSC_Account_Request@healthspring.com

   Note: Failure to provide valid information could delay access to the portal.

7. Click "**Submit**" and your account request will be submitted to the HSC Account Request inbox, to be processed

   Note: Some information may be required from provider relations representative, prior to creating the account and granting access.

8. Once all the information has been verified and loaded, users will receive an email notification with usernames and a link to create a password from: do.not.reoly@healthspring.com . If you do not receive the notification, please check any spam or junk mail folders you may have.

Need More Help? Call the HSConnect Help Line: 866-952-7596 OR E-mail the HSConnect Help Desk: HSConnectHelp@HealthSpring.com

CREDENTIALING AND RECREDENTIALING PROGRAM

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 with the Plan. No provider can be assigned a health plan effective date or be included in a provider directory without undergoing the credentialing verification and peer review process. All providers who have been initially approved for participation are required to recredential at least once every three years in order to maintain their participating status.

Practitioner Selection Criteria

Cigna-HealthSpring utilizes specific selection criteria to ensure that practitioners who apply to participate meet basic credentialing and contracting standards. At minimum these include, but are not limited to:

- Holds appropriate, current and unencumbered licensure in the state of practice as required by state and federal entities
- Holds a current, valid, and unrestricted federal DEA and state controlled substance certificate as applicable
- Is board certified or has completed appropriate and verifiable training in the requested practice specialty
- Maintains current malpractice coverage with limits commensurate with the community standard in which practitioner practices
- Participates in Medicare and has a Medicare number and/or a National Provider Identification number
- Has not been excluded, suspended and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program
- Is not currently opted out of Medicare
- Has admitting privileges at a participating facility as applicable

Application Process

1. Submit a completed State Mandated Credentialing application, CAQH Universal Credentialing Application form or CAQH ID, or the Plan's application with a current signed and dated Attestation and Consent and Release form that is less than 90 days old.
2. If any of the Professional Disclosure questions are answered yes on the application, supply sufficient additional information and explanations.
3. Provide appropriate clinical detail for all malpractice cases that are pending, or resulted in a settlement or other financial payment.
4. Submit copies of the following:
   - All current and active state medical licenses, DEA certificate(s) and state controlled substance certificate as applicable
   - Evidence of current malpractice insurance that includes the effective and expiration dates of the policy and term limits.
   - Five years of work history documented in a month/year format either on the application or on a current curriculum vitae. Explanations are required for any gaps exceeding six (6) months.
   - If a physician, current and complete hospital affiliation information on the application. If no hospital privileges and the specialty warrants hospital privileges, a letter detailing the alternate coverage arrangement(s) or the name of the alternate admitting physician should be provided.

Credentialing and Recredentialing Process

Once a Practitioner has submitted an application for initial consideration, Cigna-HealthSpring's Credentialing Department will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, and malpractice history by querying the National Practitioner Data Bank. The credentialing process generally takes up to ninety (90) days to complete, but can in some instances take longer. Once credentialing has been completed and the applicant has been approved, the Practitioner will be notified in writing of their participation effective date.

To maintain participating status, all practitioners are required to recredential at least every three (3) years. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit recredentialing information at least 4 months in advance of their three year anniversary date. Three (3) separate attempts will be made to obtain the required information via mail, fax, email or telephonic request. Practitioners who fail to return recredentialing information prior to their recredentialing due date will be notified in writing of their termination from the network.

Office Site Evaluations

Office site surveys and medical record keeping practice reviews may be required when it is deemed necessary as a result of a patient complaint, quality of care issue and/or as otherwise mandated by state regulations. Practitioner offices will be evaluated in the following categories:

1. Physical Appearance and Accessibility
2. Patient Safety and Risk Management
3. Medical Record Management and Security of Information
4. Appointment Availability

Providers who fail to pass the area of the site visit specific to the complaint or who score less than 90% on the site evaluation overall will be required to submit a corrective action plan and make corrections to meet the minimum compliance score. A follow up site evaluation will be done within sixty (60) days of the initial site visit if necessary to ensure that the correction action has been implemented.

Practitioner Rights

- Review information obtained from any outside source to evaluate their credentialing application with the exception of references, recommendations or other peer-review protected information. The provider may submit a written request to review his/her file information at least thirty days in advance at which time the Plan will establish a time for the provider to view the information at the Plan's offices.
- Right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the practitioner. 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.
- Right to be informed of the status of their application upon request. A provider may request the status of the application either telephonically or in writing. The Plan will respond within two 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 committee review date, and approval status.

Organizational Provider Selection Criteria

When assessing organizational providers, Cigna-HealthSpring utilizes the following criteria:

- Must be in good standing with all state and federal regulatory bodies
- Has been reviewed and approved by an accrediting body
- If not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other Plan criteria
- Maintains current professional and general liability insurance as applicable
- Has not been excluded, suspended and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program

Organizational Provider Application and Requirements

1. A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
2. If responded Yes to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.
3. Copies of all applicable state and federal licenses (i.e. facility license, DEA, Pharmacy license, etc).
4. Proof of current professional and general liability insurance as applicable
5. Proof of Medicare participation
6. If accredited, proof of current accreditation.
7. Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.
8. If not accredited, a copy of any state or CMS site surveys that has occurred within the last three years including evidence that the organization successfully remediated any deficiencies identified during the survey.

Organizational Site Surveys

As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies and inpatient, residential or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a recent state or CMS site survey. Any organizational provider may also be subject to a site survey as warranted subsequent to the receipt of a complaint.

Organizational providers who are required to undergo a site visit must score a minimum of 85% on the site survey tool. Providers who fall below acceptable limits will be required to submit a written Corrective Action Plan (CAP) within thirty (30) days and may be re-audited at minimum within sixty (60) days to verify specific corrective action items as needed. Providers who fail to provide an appropriate CAP or who are unable to meet minimum standards even after re-auditing will not be eligible for participation.

Credentialing ± Accreditation for DME, Orthotics and Prosthetic Providers

All Durable Medical Equipment and Orthotics and Prosthetic providers are required by Medicare to be accredited by one of the 10 national accreditation organizations. The most current listing of these organizations can be found at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizationsCMB.pdf** .

Pharmacies who provide durable medical equipment but are exempt from the accreditation requirement under Public Law #111-148 which amended title XVII of the Social Security Act, must provide the following information with their initial application:

- Evidence the pharmacy has been enrolled with Medicare as a supplier of durable medical equipment, prosthetics, orthotics and suppliers and has been issued a provider number for at least 5 years;
- An attestation that the pharmacy has met all criteria under the above referenced amendment

SNF ± Site Visit requirements

Organizational Site Surveys

As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies and inpatient, residential or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a recent (within last 3 years) state or CMS site survey.

Skilled nursing facilities that have been fined or have had denial of new admissions due to deficiencies found during annual licensure or complaint surveys conducted within the last three years must report that activity with their initial or recredentialing application. Explanations will be required for each event along with confirmation from the state licensing entity that the corrective action plan was accepted and the facility is currently in compliance with Medicare participation requirements.

Credentialing Committee/ Peer Review Process

All initial applicants and recredentialed 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 and specialty providers, and has the authority to approve or deny an appointment status to a provider. All information considered in the credentialing and recredentialing 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.

Non-Discrimination in the Decision Making Process

Cigna-HealthSpring's Credentialing Program is compliant with all guidelines from the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and State regulations as applicable. Through the universal application of specific assessment criteria, Cigna-HealthSpring ensures fair and impartial decision-making in the credentialing process. No provider shall be denied participation based solely on race, gender, age, religion, ethnic origin, sexual orientation, type of population served or for specializing in certain types of procedures.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of their plan effective date. Providers are advised to not see Cigna-HealthSpring members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee will be notified via a certified letter within sixty (60) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process & Notification of Authorities

In the event that a provider's participation is limited, suspended or terminated, 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) provides 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.

Confidentiality of Credentialing Information

All information obtained during the credentialing and recredentialing 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 recredentialing 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 subject to review by the Medical Director or the Credentialing Committee who may elect to limit, restrict or terminate participation. Any provider who's license has been revoked 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.

CLAIMS

Claims Submission

While Cigna-HealthSpring prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact Cigna-HealthSpring Provider Services for assistance at **1-800-230-6138**.

All completed claims forms should be forwarded to the address noted below:

Cigna-HealthSpring
PO Box 981804
El Paso, TX 79998

Timely Filing

As a Cigna-HealthSpring participating provider, you have agreed to submit all claims within 120 days of the date of service. Claims submitted with dates of service beyond 120 days are not reimbursable by Cigna-HealthSpring.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: **https://www.cms.gov/manuals/downloads/clm104c12.pdf**

Cigna-HealthSpring can only pay claims which are submitted accurately. The provider is at all times responsible for accurate claims submission. While Cigna-HealthSpring will make its best effort to inform the provider of claims errors, the claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties may bill and be paid without regard to their membership in the same group.

Claim Payment

Cigna-HealthSpring pays clean claims according to contractual requirements and The Centers for Medicare and Medicaid Services (CMS) guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by Cigna-HealthSpring or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for non-participating providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of Cigna-HealthSpring, the claim is not considered clean.

Offsetting

As a contracted Cigna-HealthSpring Provider, you will be informed of any overpayments or other

payments you may owe us within 365 days of the date on the Explanation of Benefits or within the timeframe as noted in your Agreement. You will have thirty (30) days from receipt of notification seeking recovery to refund us. We will provide you with the Member's name, Member's identification number, Cigna-HealthSpring's claim number, your patient account number, date of service, a brief explanation of the recovery request and the amount or the requested recovery. If you have not refunded us within the thirty (30) days recovery notice period, we will offset the recovery amounts identified in the initial notification, or in accordance with the terms of your Agreement.

Pricing

Original Medicare typically has market adjusted prices by code (i.e. CPT or HCPCS) for services that Original Medicare covers. However, there are occasions where Cigna-HealthSpring offers a covered benefit for which Medicare has no pricing. In order to expedite claims processing and payment in these situations, Cigna-HealthSpring will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. Cigna-HealthSpring requests that you make every effort to submit claims with standard coding. As described in this Manual and/or your Agreement, you retain your rights to submit a Request for Reconsideration if you feel the reimbursement was incorrect.

Claims Encounter Data

Providers who are being paid under capitation must submit claims in order to capture encounter data as required per your Cigna-HealthSpring Provider Agreement.

Explanation of Payment (EOP) / Remittance Advice (RA)

The EOP/RA statement is sent to the provider after coverage and payment have been determined by Cigna-HealthSpring. The statement provides a detailed description of how the claim was processed.

Non Payment / Claim Denial

Any denials of coverage or non-payment for services by Cigna-HealthSpring will be addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed per each billed line if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP/RA. Per your contract, the member may or may not be billed for services denied by Cigna-HealthSpring.

The member may not be billed for a covered service when the provider has not followed the Cigna-HealthSpring procedures. In some instances, providing the needed information may reverse the denial (i.e. referral form with a copy of the EOP / RA, authorization number, etc…). When no benefits are available for the member, or the services are not covered, the EOP/RA will alert you to this and you may bill the member.

Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice AND the premium Cigna-HealthSpring receives from The Centers for Medicare & Medicaid Services (CMS) is adjusted to hospice status, the financial responsibility for that member shifts from Cigna-HealthSpring to Original Medicare. While these two conditions exist, Original Medicare covers all Medicare–covered services rendered. The only services Cigna-HealthSpring is financially responsible for during this time include any benefits Cigna-HealthSpring offers above Original Medicare benefits that are non-hospice related, non-Medicare covered services such as vision (eyewear allowable), prescription drug claims, medical visit transportation, etc..

Until both conditions listed above have been met, Cigna-HealthSpring remains financially responsible for the member. Example: If a member is certified hospice on the 8th of the month, Cigna-HealthSpring continues to be financially responsible for that member until the end of that month. The financial responsibility shifts to Original Medicare on the 1st day of the following month; the date the CMS premium to Cigna-HealthSpring has been adjusted to hospice status for that member. These rules apply for both professional and facility charges.

ICD-10 Diagnosis and Procedure Code Reporting Begins October 1, 2014

In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors and other health care professionals, as well as vendors and trading partners.

ICD-10 (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

- ICD-10-CM for Diagnosis coding is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 characters instead of the 3 to 5 characters used with ICD-9-CM, adding more specificity.

Displaced fracture of neck of right radius, initial encounter for closed fracture

- ICD-10-PCS for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric characters instead of the 3 or 4 numeric characters used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

Resection of appendix, percutaneous endoscopic approach

Note: Procedure codes are only applicable to claims and not prior authorizations.

The transition to ICD-10 is occurring because ICD-9 codes have limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT coding for outpatient procedures.

ICD-9 vs. ICD-10 Claim Submission Guidelines

Health care professionals must be prepared to comply with the transition to ICD-10 by October 1, 2014. Cigna-HealthSpring will strictly adhere to the following guidelines:

- All electronic transactions must use Version 5010 standards, which have been required since January 1, 2012. Unlike the older Version 4010/4010A standards, Version 5010 accommodates ICD-10 codes.
- Professional and outpatient claims submitted with a date of service or inpatient claims submitted with a discharge date prior to October 1, 2014 must be processed using ICD-9 codes.
- Professional and outpatient claims submitted with a date-of-service or inpatient claims submitted with a discharge date on or after October 1, 2014 must be processed using ICD-10 codes.
- Claims with ICD-9 codes for date of service or discharge provided on or after October 1, 2014 will be rejected.
- Claims with ICD-10 codes for date of service or discharge provided prior to October 1, 2014 will be rejected.
- Claims submitted with a mix of ICD-9 and ICD-10 codes will be rejected. Claims should be coded based on date of service (outpatient) or discharge date (inpatient).
- Some institutional claims, such as those for long-term or on-going care should be processed as split claims during the transition period. With such a split claim, all services rendered during a particular cycle before October 1, 2014 would be accounted for on one claim with ICD-9 codes. The other remaining services rendered on or after October 1, 2014 during that same cycle would be accounted for on a separate claim using ICD-10 codes.
- We can process claims after the compliance date with ICD-9 codes with dates of service or discharge dates prior to October 1, 2014, for a period of time to allow for claim run-off:
  - Appeals with dates of service or discharge dates before October 1, 2014 should be submitted with the appropriate ICD-9 codes.
- Corrected or resubmitted claims with dates of service or discharge dates before October 1, 2014 should be submitted with the correct ICD-9 codes to the claim office for adjustment or correction.

Billable vs. Non-billable Codes

- A billable ICD-9 or ICD-10 code is defined as a code that has been coded to its highest level of specificity.
- A non-billable ICD-9 or ICD-10 code is defined as a code that has not been coded to its highest level of specificity. If a claim is submitted with a non-billable code, the claim will be rejected.
- The following are examples of billable ICD-9 codes with corresponding non-billable codes:
  - **Billable ICD-9 Codes**
    473.0 – Chronic maxillary sinusitis
    473 – Chronic sinusitis
  - **Non-billable ICD-9 Codes**
    474.00 – Chronic tonsillitis
    474 – Chronic disease of tonsils and adenoids
- The following is an example of a billable ICD-10 code with corresponding non-billable codes:
  - **Billable ICD-10 Code**
    M1A.3110 – Chronic gout due to renal impairment, right shoulder, without tophus

- **Non-billable ICD-10 Codes**
  M1A.3 – Chronic gout due to renal impairment
  M1A.31 – Chronic gout due to renal impairment, shoulder
  M1A.311 – Chronic gout due to renal impairment, right shoulder
- It is acceptable to submit a claim using an unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.
- **Unspecified ICD-9 Code**
  428.0 – Congestive heart failure, unspecified
  486 – Pneumonia, organism unspecified
- **Unspecified ICD-10 Code**
  I50.9 – Heart failure, unspecified
  J18.9 – Pneumonia, unspecified organism

Questions Concerning ICD-10

If you have a question as it pertains to ICD-10, please consult with your Network Operations Representative.

Coordination of Benefits and Subrogation Guidelines

General Definitions

Coordination of Benefits (COB): Benefits that a person is entitled to under multiple plan coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding one hundred (100) percent of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners (NAIC) COB Model Regulations Guidelines.

Order of Benefit Determination Rule: Rules which, when applied to a particular member covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in providing benefits for that member. A plan will be determine to have Primary or Secondary responsibility for a person's coverage with respect to other plans by applying the NAIC rules.

Primary: This carrier is responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists.

Secondary: This carrier is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment not to exceed the total amount billed (maintenance of benefits).

Allowable Expense: Any expense customary or necessary, for health care services provided as well as covered by the member's Health Care Plan.

Conclusion: COB is applying the NAIC rules to determine which plan is primarily responsible and plan would be in a secondary position when alternate coverage exists. If COB is to accomplish its purpose, all plans must adhere to the structure set forth in the Model COB regulations.

Basic NAIC Rules for COB

Birthday Rule: The primary coverage is determined by the birthday that falls earliest in the year, understanding both spouses are employed and have coverage. Only the day and month are taken into consideration. If both members have the same date of birth, the plan which covered the member the longest is considered primary

Basic NAIC Rules for COB

General Rules: The following table contains general rules to follow to determine a primary carrier:

If The Member/Beneficiary….	The Below Conditions Exists	Then The Below Program Pays First	The Below Program Pays Secondary
Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family members current employment	The employer has more than 20 employees, or at least one employer is a multi-employer group that employs 20 or more employees	The Group Health Plan (GHP) pays primary	Cigna-HealthSpring/ Medicare pays secondary
Is age 65 or older and is covered a Group Health Plan (GHP) through current employment or a family members current employment	The employer has less than 20 employees	Cigna-HealthSpring / Medicare pays primary	Group Health Plan (GHP) pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family members current employment…	The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees	The Large Group Health Plan (LGHP) pays primary	Cigna-HealthSpring / Medicare pays secondary

If The Member/Beneficiary….	The Below Conditions Exists	Then The Below Program Pays First	The Below Program Pays Secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family members current employment…	The employer employs less than 100 employees	Cigna-HealthSpring / Medicare pays primary	Large Group Health Plan (LGHP) pays secondary
Is age 65 or older or entitled based on disability and has retirement insurance only	Does not matter the number of employees	Cigna-HealthSpring / Medicare pays primary	Retirement Insurance pays secondary
Is age 65 or older or is entitled based on disability and has COBRA coverage	Does not matter the number of employees	Cigna-HealthSpring/ Medicare pays primary	COBRA pays secondary
Becomes dually entitled based on age/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block one above	The Group Health Plan (GHP) pays primary for the first 30 months	Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)
Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance	Had insurance prior to becoming dually entitled with ESRD as in block one above and then retired	The Retirement Insurance pays primary for the first 30 months	Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)
Becomes dually entitled based on age/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block one above and picks up COBRA coverage	COBRA insurance would pay primary for the first 30 months (or until the member drops the COBRA coverage	Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)
Becomes dually entitled based on disability/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block three above	The Large Group Health Plan (LGHP) pays primary	Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)
Becomes dually entitled based on disability/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block three above and picks up the COBRA coverage	COBRA insurance would pay primary for the first 30 months or until the member drops the COBRA coverage	Cigna-HealthSpring/Medicare pays secondary (after 30 months Cigna-HealthSpring pays primary)

Basic Processing Guidelines for COB

For Cigna-HealthSpring to be responsible as either the primary or secondary carrier, the member must follow all HMO rules (i.e. pay co-pays and follow appropriate referral process).

When Cigna-HealthSpring is the secondary insurance carrier:

- All Cigna-HealthSpring guidelines must be met in order to reimburse the provider (i.e. pre-certification, referral forms, etc...)
- The provider collects only the co-payments required
- Be sure to have the member sign the "assignment of benefits" sections of the claim form
- Once payment and/or EOB are received from the other carriers, submit another copy of the claim with the EOB of Cigna-HealthSpring for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When Cigna-HealthSpring is the primary insurance carrier:

- The provider collects the co-payment required under the member's Cigna-HealthSpring plan
- Submit the claim to Cigna-HealthSpring first
- Be sure to have the member sign the "assignment of benefits" sections of the claim form

- Once payment and/or remittance advise (RA) has been received from Cigna-HealthSpring, submit a copy of the claim with the RA to the secondary carrier for adjudication

Please note that Cigna-HealthSpring is a total replacement for Medicare.

- Medicare cannot be secondary when members have Cigna-HealthSpring.
- Medicaid will not pay the co-pay for Cigna-HealthSpring members.

Worker's Compensation

Cigna-HealthSpring does not cover worker's compensation claims.

When a provider identifies medical treatment as related to an on-the-job illness or injury, Cigna-HealthSpring must be notified. The provider will bill the worker's compensation carrier for all services rendered, not Cigna-HealthSpring.

Subrogation

Subrogation is the coordination of benefits between a health insurer and a third party insurer (i.e. property and casualty insurer, automobile insurer, or worker's compensation carrier), not two health insurers.

Claims involving Subrogation or Third Party Recovery (TPR) will be processed internally by the Cigna-HealthSpring Claims Department. COB protocol, as mentioned above, would still apply in the filing of the claim.

Members who may be covered by third party liability insurance should only be charged the required co-payment. The bill can be submitted to the liability insurer. The provider should submit the claim to Cigna-HealthSpring with any information regarding the third party carrier (i.e. auto insurance name, lawyers name, etc...). All claims will be processed per the usual claims procedures.

Cigna-HealthSpring uses an outside vendor for review and investigation of all possible subrogation cases. This vendor coordinates all requests for information from the member, provider and attorneys office and assists with settlements. For claims related questions, please contact Provider Customer Service at **1-800-230-6138**. A Provider Representative will gladly provide assistance.

Appeals

You may appeal a previous decision not pay for a service, including a decision to pay for a different level of care; this includes not just outright denials, but also "partial" ones. Examples of partial denials include denials of certain levels of care, line items on a claim, or a decreased number of office or therapy visits. Partial denials of payment may be appealed using the same processes as appeals of full denials. Your appeal will receive an independent review (made by someone not involved in the initial decision) at Cigna-HealthSpring. Requesting an appeal does not guarantee that your request will be approved or your claim paid. The appeal decision may still be to fully or partially uphold the original decision. You have one level of appeal, so that decision is final.

You may appeal, on behalf of a member, a health services/UM denial of a service not yet provided. The member will need to be advised that you are appealing on his or her behalf. Member appeals are processed according to Medicare rules.

An appeal must be submitted to the address/fax listed below within 60 days from the original decision. You must include with your appeal request a copy of your denial, any medical records that would support why the service is needed, and if for a hospital stay or office visit, a copy of the insurance verification done on the date of service or admission.

Appeals can take up to 60 days to be processed. The time frame in which a claim must be filed to be considered timely is not impacted or affected or changed by the appeal process or the appeal outcome. If the appeal decision results in approval of payment that is contingent on the filing of a corrected claim, the time frame is not automatically extended and remains consistent with the timely filing provision in the Cigna-HealthSpring Agreement.

An Appeal is the request for Cigna-HealthSpring to review a previously made decision. You must receive a Notice of Denial of Medical Non-Coverage or Remittance Advice before you can submit an appeal. Please do not send initial claims as appeals.

Part C Appeals Addresses and Fax Numbers

State	Address	Phone #
TN GA North MS	Cigna-HealthSpring Attn: Appeals Unit PO Box 24087 Nashville, TN 37202-4087	**1-800-511-6943**
		Fax #
		1-800-931-0149

HEALTHCARE PLAN EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

HEDIS (a standardized data set) 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

include measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Glaucoma Screening for Older Adults, Controlling High Blood Pressure, Breast Cancer Screening, and Colorectal Cancer Screening.

Plan-wide HEDIS measures are reported annually and represent a mandated activity for Health Plans contracting with the Centers for Medicare and Medicaid Services (CMS). Each spring, Cigna-HealthSpring Representatives will be required to collect from practitioner offices copies of medical records to establish HEDIS scores. Selected practitioner 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's HEDIS results are available upon request. Contact the Health Plan's Quality Improvement Department to request information regarding those results.

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

STARS GUIDANCE

The Center for Medicare and Medicaid Services (CMS) uses the Five-Star Quality Rating System to determine how much to compensate Medicare Advantage plans and educate consumers on health plan quality. The Star Ratings system consists of over 50 measures from five different rating systems. The cumulative results of these measures make up the Star rating assigned to each health plan.

Star Ratings have a significant impact on the financial outcome of Medicare Advantage health plans by directly influencing the bonus payments and rebate percentages received. CMS will award quality-based bonus payments to high performing health plans based on their Star Ratings performance. For health plans with a four star or more rating, a bonus payment is paid in the form of a percentage (maximum of five percent) added to the county benchmark. [A county benchmark is the amount CMS expects it to cost to provide hospital and medical insurance in the state and county.] After 2015, any health plans with Star Ratings below four will no longer receive bonus payments

Star Rating Components

The Star Rating is comprised of over 50 different measures from six different rating systems:

Star Rating System:

- HEDIS-The Healthcare Effectiveness Data and Information Set is a set of performance measures developed for the managed care industry. All claims are processed regularly to extract the NCQA (National Committee for Quality Assurance) defined measures. For example, this allows the health plan and CMS to determine how many enrollees have been screened for high blood pressure.
- CAHPS- Consumer Assessment of Healthcare Providers and Systems is a series of patient surveys rating healthcare experiences that is performed on behalf of CMS by an approved vendor.
- CMS- Center for Medicare and Medicaid services rates each plan on administrative type metrics, such as, beneficiary access, complaints, call center hold times and percentage of members choosing to leave a plan.
- PDE- Prescription Drug Events is data collected on various medications related events, such as, high-risk medications, adherence for chronic conditions and pricing.
- HOS- Health Outcomes Survey is a survey that uses patient-reported outcomes over a 2.5-year time span to measure health plan performance. Each spring a random sample of Medicare beneficiaries is drawn from each participating Medicare Advantage Organization (MAO) that has a minimum of 500 enrollees and is surveyed. Two years later, these same respondents are surveyed again (i.e., follow up measurement).
- IRE- Medicare Advantage plans are required to submit all denied enrollee appeals (Reconsiderations) to an Independent Review Entity (MAXIMUS Federal Services).

These systems rate the plans based on five domains:

1. Staying Healthy: Screenings, Tests and Vaccines
2. Managing Chronic (Long Term) Conditions
3. Member Experience with Health Plan
4. Member Complaints, Problems Getting Services, and Improvement in the Health Plan's Performance
5. Health Plan Customer Service
6. Data used to calculate the ratings comes from surveys, observation, claims data and medical records.

CMS continues to evolve the Star ratings system by adding, removing and adjusting various measures on

a yearly basis. CMS weights each measure between one and three points. A three point measure, or triple weighted measure, are those measures that CMS finds most important and should be a focus for health plans. The composition of all rating systems is indicated below.

Health Reform

The Patient Protection and Affordable Care Act (PPACA) requires that Medicare Advantage plans be awarded quality-based bonus payments beginning in 2012, as measured by the Star ratings system. Bonus payments are provided to MA plans that receive four or more stars.

CMS assigns a benchmark amount to each county within a state, which is the maximum amount CMS will pay to provide hospital and medical benefits. All MA plans submit a bid, which is the projected cost to operate MA within the county. The spread between the bid and original benchmark is called the rebate. A bonus payment is the percentage added to the county benchmark, which increases the spread and the amount of revenue received by the health plan.

Plan Quality Score	2012-13	2014	2015 and after
Less than 3 stars	—	—	—
3 stars	3.0%	3.0%	—
3.5 stars	3.5%	3.5%	—
4 stars	4.0%	5.0%	5.0%
4.5 stars	4.0%	5.0%	5.0%
5 stars	5.0%	5.0%	5.0%

Star Measure Weighting:

Individual Star measures can be single-weighted, 1.5-weighted or triple-weighted, with higher weight being given to those measures that CMS deems most important by which to measure plan quality. Triple-weighted measures are typically outcomes measures that measure a health plan's ability to manage chronic illnesses and keep members healthy. Certain disease states appear in multiple measures. For example, diabetes directly impacts 7 measures and cardiovascular conditions directly impact 4 measures.

Following is a summary of the weighting of all Star measures:

Part C Star Rating Measure	Weight
Breast Cancer Screening (HEDIS)	1
Colorectal Cancer Screening (HEDIS)	1
Cardio Care- LDL Screen (HEDIS)	1
Comprehensive Diabetes Care - LDL Screen (HEDIS)	1
Glaucoma Testing (HEDIS)	1
Annual Flu Vaccine (CAHPS)	1
Improving/Maintaining Physical Health (HOS)	3
Monitoring Physical Activity (HOS)	1
Adult BMI Assessment (HEDIS)	1
Care For Older Adults - Medication Review (HEDIS)	1
Care For Older Adults - Pain Screening (HEDIS)	1
Osteoporosis Fracture Management (HEDIS)	1
Comprehensive Diabetes Care - Eye Exam (HEDIS)	1
Comprehensive Diabetes Care - Kidney Disease(HEDIS)	1
Comprehensive Diabetes Care - HBA1C ≤ 9 (HEDIS)	3
Comprehensive Diabetes Care - LDL < 100mg/DL (HEDIS)	3
Controlling Blood Pressure (HEDIS)	3
Rheumatoid Arthritis Management (HEDIS)	1
Improving Bladder Control (HOS)	1
Reducing Risk Of Falling (HOS)	1
Plan All Cause Readmissions (HEDIS)	3
Getting Needed Care Without Delays (CAHPS)	1.5
Getting Appointments And Care Quickly (CAHPS)	1.5
Customer Service (CAHPS)	1.5
Overall Rating Of Healthcare Quality (CAHPS)	1.5
Overall Rating Of Plan (CAHPS)	1.5
Care Coordination (CAHPS)	1.5
Complaints About The Health Plan (CTM)	1.5
Beneficiary Access And Performance Problems (CMS)	1.5
Members Choosing To Leave The Plan (CMS)	1.5
Improvement (CMS)	3
Plan makes Timely Decisions About Appeals (IRE)	1.5
Reviewing Appeals Decisions (IRE)	1.5
Foreign language Interpreter and TTY/ TDD Availability (Call Center)	1.5

Part D Star Rating Measure	Weight
Foreign language Interpreter and TTY/ TDD Availability (Call Center) Appeals Autoforward (IRE)	1.5 1.5
Appeals Upheld (IRE)	1.5
Complaints About The Health Plan (CTM)	1.5
Beneficiary Access And Performance Problems (CMS)	1.5
Members Choosing To Leave The Plan (CMS)	1.5
Improvement (CMS)	3
Rating Of Drug Plan CAHPS)	1.5
Getting Needed Prescription Drugs (CAHPS)	1.5
MPF Pricing Accuracy (PDE)	1
High Risk Medications (PDE)	3
Diabetes Treatment (PDE)	3
Medication Adherence For Oral Diabetes Medications (PDE)	3
Medication Adherence For Hypertension (PDE)	3
Medication Adherence For Cholesterol (PDE)	3

Star Rating Timeline

The Star rating process follows a unique lag timeline that must be iterated. Each year, CMS publishes Health Plan ratings in October which encompass data collected in the previous year. After ratings are determined, bonuses payments can be included in the bid process for the following year. This means that actions taken to affect Stars in a given year take almost three years to realize financially. For example:

	Year 1	Year 2	Year 3	Year 4	Year 5
	CY2011	CY2012	CY2013	CY2014	CY2015
2013 Star Rating (Publish Oct. 2012	Quality Activities to Impact 2013 Rating	2013 Rating Published (Oct.)	2013 Rating Included in 2014 Bid Process	2013 Rating Bonuses Distributed	N/A
2014 Star Rating (Published Oct. 2013	N/A	Quality Activities to Impact 2014 Rating	2014 Rating Published (Oct.)	2014 Rating Included in 2014 Bid Process	2014 Rating Bonuses Distributed

BEHAVIORAL HEALTH

Cigna-HealthSpring provides comprehensive mental health and substance abuse services to its members. Its goal is to treat the member in the most appropriate, least restrictive level of care possible, and to maintain and/or increase functionality.

Cigna-HealthSpring's network is comprised of mental health and substance abuse services and providers who identify and treat members with behavioral health care needs.

Integration and communication among behavioral health and physical health providers is most important. Cigna-HealthSpring encourages and facilitates the exchange of information between and among physical and behavioral health providers. Member follow-up is essential. High risk members are evaluated and encouraged to participate in Cigna-HealthSpring's behavioral health focused Case Management Program where education, care coordination, and support is provided to increase member's knowledge and encourage compliance with treatment and medications. Cigna-HealthSpring works with its providers to become part of the strategy and the solution to provide quality behavioral health services.

Behavioral Health Services

Behavioral Health services are available and provided for the early detection, prevention, treatment, and maintenance of the member's behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a member may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Mental health and substance abuse benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care.

Behavioral Health services include:

- Access to Cigna-HealthSpring's Customer Service for orientation and guidance
- Routine outpatient services to include psychiatrist, addicitionologist, licensed psychologist and LCSWs, and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice
- Initial evaluation and assessment
- Individual and group therapy
- Psychological testing according to established guidelines and needs

- In-patient hospitalization
- Inpatient and out-patient detoxification treatment
- Medication management
- Partial hospitalization programs

Responsibilities of Behavioral Health Providers:

Cigna-HealthSpring encourages behavioral health providers to become part of its network. Their responsibilities include but are not limited to:

- Provide treatment in accordance with accepted standards of care
- Provide treatment in the least restrictive level of care possible
- Communicate on a regular basis with other medical and behavioral health practitioners who are treating or need to treat the member
- Direct members to community resources as needed to maintain or increase member's functionality and ability to remain in the community

Responsibilities of the Primary Care Physician:

the PCP can participate in the identification and treatment of their member's behavioral health needs. His/her responsibilities include:

- Screening and early identification of mental health and substance abuse issues
- Treating members with behavioral health care needs within the scope of his/her practice and according to established clinical guidelines. These can be members with co-morbid physical and minor behavioral health problems or those members refusing to access a mental health or substance abuse provider, but requiring treatment
- Consultation and/or referral of complex behavioral health patients or those not responding to treatment
- Communication with other physical and behavioral health providers on a regular basis

Access to Care

Members may access behavioral health services as needed:

- Members may self refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Members may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP's scope of practice. They may request a referral to a behavioral health practitioner. Referrals however, are not required to receive most in-network mental health or substance abuse services
-
- Members and providers can call Cigna-HealthSpring Behavioral Health Customer Service to receive orientation on how to access behavioral health services, provider information, and prior authorizations at **1-866-780-8546.**

Medical Record documentation

When requesting prior authorization for specific services or billing for services provided, behavioral health providers must use the DSM-IV multi-axial classification system and document a complete diagnosis. The provision of behavioral health services require progress note documentation that correspond with day of treatment, the development of a treatment plan, and discharge plan as applicable for each member in treatment.

Continuity of Care

Continuity of Care is essential to maintain member stability. Behavioral health practitioners and PCPs, as applicable, are required to:

- Evaluate member if he/she was hospitalized for a behavioral health condition within 7 days post-discharge
- Provide members receiving care with contact information for any emergency or urgent matter arising that necessitates communication between the member and the provider
- Evaluate member needs when the member is in acute distress
- Communicate with the member's other healthcare providers
- Identify those members necessitating follow-up and refer to Cigna-HealthSpring's behavioral health focused Case Management Program as necessary
- Discuss cases as needed with a peer reviewer
- Make request to Cigna-HealthSpring for authorization for member in an active course of treatment with a non-participating practitioner

Utilization Management

Cigna-HealthSpring's Health Services Department coordinates behavioral health care services to ensure appropriate utilization of mental health and substance abuse treatment resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically-appropriate, and cost-effective manner for the members.

Cigna-HealthSpring Utilization Management staff base their utilization-related decisions on the clinical needs of members, the member's Benefit Plan, Interqual Criteria, the appropriateness of care, Medicare National Coverage Guidelines, health care objectives, and scientifically-based clinical criteria and treatment guidelines in

the context of provider and/or member-supplied clinical information and other relevant information.

HEALTH SERVICES

Cigna-HealthSpring's Health Services Department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality- oriented, timely, clinically-appropriate, and cost-effective manner for the members.

Cigna-HealthSpring Utilization Management staff base their utilization-related decisions on the clinical needs of members, the member's Benefit Plan, Interqual Criteria, Milliman Guidelines, the appropriateness of care, Medicare National Coverage Guidelines, health care objectives, and scientifically-based clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information and other such relevant information.

Cigna-HealthSpring in no way rewards or incentivizes, either financially or otherwise, practitioners, utilization reviewers, clinical care managers, physician advisers or other individuals involved in conducting utilization review, for issuing denials of coverage or service, or inappropriately restricting care.

Goals

- To ensure that services are authorized at the appropriate level of care and are covered under the member's health plan benefits;
- To monitor utilization practice patterns of Cigna-HealthSpring's contracting physicians, contracting hospitals, contracting ancillary services, and contracting specialty providers;
- To provide a system to identify high-risk members and ensuring that appropriate care is accessed;
- To provide utilization management data for use in the process of re-credentialing providers;
- To educate members, physicians, contracted hospitals, ancillary services, and specialty providers about Cigna-HealthSpring's goals for providing quality, value-enhanced managed health care; and
- To improve utilization of Cigna-HealthSpring's resources by identifying patterns of over- and under-utilization that have opportunities for improvement.

Departmental Functions

- Prior Authorization
- Referral Management
- Concurrent Review
- Discharge Planning
- Case Management and Disease Management
- Continuity of Care

Prior Authorization

The Primary Care Physician (PCP) or Specialist is responsible for requesting prior authorization of all scheduled admissions or services/procedures, for referring a member for an elective admission, outpatient service, and for requesting services in the home. Cigna-HealthSpring recommends calling at least five (5) days in advance of the admission, procedure, or service. Requests for prior authorization are prioritized according to level of medical necessity. For prior authorizations, providers should call **1-800-453-4464**, option 4. You may also submit most requests via our online portal 24 hours per day, 7 days per week at: **https://Cigna-HealthSpring.hsconnectonline.com/HSConnect.**

Services requiring prior authorization are listed in the appendix section of this manual, as well as on Cigna-HealthSpring's website. The presence or absence of a service or procedure on the list does not determine coverage or benefits. Call Customer Service to verify benefits, coverage, and member eligibility.

The Prior Authorization Department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization, including:

Verification that the member is enrolled with Cigna-HealthSpring at the time of the request for authorization and on each date of service.

- Verification that the requested service is a covered benefit under the member's benefit package.
- Determination of the appropriateness of the services (medical necessity).
- Verification that the service is being provided by the appropriate provider and in the appropriate setting.
- Verification of other insurance for coordination of benefits.

The Prior Authorization Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes the authorization determination, and notifies the provider of the determination.

Examples of information required for a determination include, but are not limited to:

- Member name and identification number
- Location of service (e.g., hospital or surgi-center setting)
- Primary Care Physician name
- Servicing/Attending physician name
- Date of service
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code

- Clinical information supporting the need for the service to be rendered

For members who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a member appears at an emergency room for care which is non-emergent, the PCP should be contacted for direction. The member may be financially responsible for payment if the care rendered is non-emergent. Cigna-HealthSpring also utilizes urgent care facilities to treat conditions that are non-emergent but require immediate treatment.

Emergency admissions must be precertified by Cigna-HealthSpring within twenty-four (24) hours, or the next business day, of admission. Please be prepared to discuss the member's condition and treatment plan with our nurse coordinator.

Outpatient Prior Authorization Department

Triage Unit:

- Consists of non-clinical personnel
- Receives all faxes and phone calls for services that require prior authorization
- Handles issues that can be addressed from a non-clinical perspective:
  - Did you receive my fax?
  - Does xxxx procedure/service require auth?
  - Setting up "shells" for services that must be forwarded to clinical personnel for determination

Prior Authorization Unit:

- Consists of RN's and LPN's
- Teams of nurses are organized based on member's PCP or provider specialty
- Handles all issues that require a clinical determination, such as:
  - Infusion
  - Outpatient Surgical Procedures
  - DME / O&P
  - Ambulance transports
  - Outpatient Diagnostic Testing
  - Outpatient Therapy

ICD-10 Diagnosis and Procedure Code Reporting Begins October 1, 2014

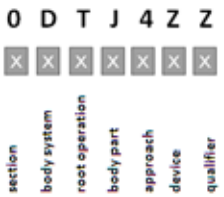
In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors and other health care professionals, as well as vendors and trading partners.

ICD-10 (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

- ICD-10-CM for Diagnosis coding is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 characters instead of the 3 to 5 characters used with ICD-9-CM, adding more specificity.

Displaced fracture of neck of right radius, initial encounter for closed fracture

- ICD-10-PCS for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric characters instead of the 3 or 4 numeric characters used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.



Resection of appendix, percutaneous endoscopic approach

Note: Procedure codes are only applicable to claims and not prior authorizations.

The transition to ICD-10 is occurring because ICD-9 codes have limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT coding for outpatient procedures.

ICD-9 vs. ICD-10 Prior Authorization Guidelines

Health care professionals must be prepared to comply with the transition to ICD-10 by October 1, 2014. Cigna-HealthSpring will strictly adhere to the following guidelines:

- Prior authorizations for services requested prior to October 1, 2014 must be submitted with ICD-9 diagnosis codes.

- Prior authorizations for services requested on or after October 1, 2014 must be submitted with ICD-10 diagnosis codes.
- If a prior authorization crosses the October 1, 2014 compliance date, we will accept services with ICD-9 codes if the prior authorization was requested prior to October 1, 2014. Two separate authorizations, one before October 1, 2014 and one on or after October 1, 2014 will not be required.
- Prior authorizations with ICD-10 diagnosis codes cannot be accepted until on or after October 1, 2014.

Billable vs. Non-billable Codes

A billable ICD-9 or ICD-10 code is defined as a code that has been coded to its highest level of specificity.

Billable ICD-9 Codes	Non-billable ICD-9 Codes
473.0 - Chronic maxillary sinusitis	473 - Chronic sinusitis
474.00 - Chronic tonsillitis	474 - Chronic disease of tonsils and adenoids

A non-billable ICD-9 or ICD-10 code is defined as a code that has not been coded to its highest level of specificity. Cigna-HealthSpring cannot process a prior authorization with a non-billable code.

Billable ICD-10 Codes	Non-billable ICD-10 Codes
M1A3110 - Chronic gout due to renal impairment, right shoulder, without tophus	M1A3 - Chronic gout due to renal impairment
	474 - Chronic disease of tonsils and adenoids
	M1A311- Chronic gout due to renal impairment, right shoulder

The following are examples of billable ICD-9 codes with corresponding non-billable codes:

Billable ICD-9 Codes	Non-billable ICD-9 Codes
428 - Congestive heart failure, unspecified	150.9 - Heart Failure, unspecified
486- Pneumonia, organism unspecified	J18.9 - Pneumonia, unspecified organism

Decisions and Time Frames

Emergency - Authorization is not required

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Expedited:

An expedited request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined within 72 hours or as soon as the member's health requires.

Routine:

If all information is submitted at the time of the request, CMS mandates a healthplan determination within 14 calendar days.

Once the Precertification Department receives the request for authorization we will review the request using nationally recognized industry standards or local coverage determination criteria. If the request for authorization is approved, Cigna-HealthSpring will assign an authorization number and enter the information in our medical management system. This authorization number can be used to reference the admission, service or procedure.

The requesting provider has the responsibility of notifying the member that services are approved and documenting the communication in the medical record.

Retrospective Review

Retrospective review is the process of determining coverage for clinical services by applying quidelines/ criteria to support the claim adjudication process after the opportunity for precertification or concurrent review timeframe has passed. The only scenarios in which retrospective requests can be accepted are:

- Authorizations for claims billed to an incorrect carrier
  - As long as you have not billed the claim to Cigna-HealthSpring and received a denial, you can request a retro authorization from Health Services within 2 business days of receiving the RA from the incorrect carrier.
  - If the claim has already been submitted to Cigna-HealthSpring and you have received a denial, the request for retro authorization then becomes an appeal and you must follow the guidelines for submitting an appeal.

- Services / Admissions after hours, weekends, or holidays
    - Cigna-HealthSpring will retrospectively review any medically necessary services provided to Cigna-HealthSpring Members after hours, holidays, or weekends. Cigna-HealthSpring does require the retro authorization request and applicable clinical information to be submitted to the Health Services dept. within 2 business days of providing the service or admitting the Member.

In accordance with Cigna-HealthSpring policy, retrospective requests for authorizations not meeting the scenarios listed above may not be accepted and these claims may be denied for payment.

After confirming the member's eligibility and the availability of benefits at the time the service was rendered, providers should submit all supporting clinical documentation with the request for review and subsequent reimbursement via fax to [TN and IL: **1-866-287-5834**/ AL: **1-205-444-4263**, MS: **1-855-595-2205**, and NFL: /GA: **1-855-388-1452**/NC: **1-855-500-2774** and SC: **1-855-420-4717**/TX:]. Please refer to the Prior Authorization Grid on page 49 based on your specific service for authorization guidelines and/or requirements.

The requesting provider has the responsibility of notifying the member that services are approved and documenting the communication in the medical record.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital admission, rehabilitation admission or skilled nursing facility or other inpatient admission in order to ensure:

- Covered services are being provided at the appropriate level of care; and
- Services are being administered according to the individual facility contract.

Cigna-HealthSpring requires admission notification for the following:

- Elective Admissions
- ER and Urgent Admissions
- Transfers to Acute Rehabilitation, LTAC and SNF Admissions
- Admissions following outpatient procedures or observation status
- Observation Status
- Newborns remaining in the hospital after the mother is discharged.

Emergent or urgent admission notification must be received within twenty-four (24) hours of admission or next business day, whichever is later, even when the admission was prescheduled. If the member's condition is unstable and the facility is unable to determine coverage information, Cigna-HealthSpring requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information to hospital professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

Cigna-HealthSpring's Health Services department complies with individual facility contract requirements for concurrent review decisions and timeframes.

Cigna-HealthSpring's licensed nurses, utilizing CMS guidelines and nationally accepted, evidence based review criteria, will conduct medical necessity review. Cigna-HealthSpring is responsible for final authorization.

Cigna-HealthSpring's preferred method for concurrent review is a live dialogue between our Concurrent Review nursing staff and the facility's UM staff within 24 hours of notification or on the last covered day. If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information Cigna-HealthSpring has available. If it is not feasible for the facility to contact Cigna-HealthSpring via phone, facilities may fax the member's clinical information within 24 hours of notification to East, West, Mid TN GA: **1-866-287-5834**; Skilled Nursing Facility (SNF) Reviews should be faxed to: **1-615-401-1589**. For SNF admission requests, a recent PM&R or physical, occupational and/or speech therapy consult is requested along with the most recent notes for therapy(ies) or recent medical status and expected skilled treatment and service requirements.

Following an initial determination, the concurrent review nurse will request additional updates from the facility on a case-by-case basis. Cigna-HealthSpring will render a determination within 24 hours of receipt of complete clinical information. Cigna-HealthSpring's nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a favorable determination. Clinical update information should be received 24 hours prior to the next review date.

A Cigna-HealthSpring Medical Director reviews all acute, rehab, LTAC and SNF confinements that do not meet medical necessity criteria and issues a determination. If the Cigna-HealthSpring Medical Director deems that the inpatient or SNF confinement

does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The Concurrent Review nurse or designee will notify the provider(s) e.g. facility, attending/ordering provider verbally and in writing of the adverse determination via Notice of (Inpatient) Denial of Medicare

Coverage (NDMC). The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made. **For SNF/Rehab call 1-615-291-7039, ext. 2032, or for Acute LTAC, call your inpatient nurse or 1-800-453-4464 Monday - Friday.**

In those instances where the Attending provider does not agree with the determination, the provider is encouraged to contact Cigna-HealthSpring's Medical Director for Peer-to-Peer discussion. T**he telephone number to contact our Medical Director for the discussion is 1-615-291-7039 x2032 for SNF/Rehab. Please contact your inpatient nurse or 1-800-453-4464 to be redirected. Call 1-800-453-4464 for outpatient and elective services.** Following the Peer-to-Peer discussion, the Medical Director will either reverse the original determination and authorize the confinement or uphold the adverse determination.

For members receiving hospital care and for those who transfer to a Skilled Nursing Facility or Acute Inpatient Rehabilitation Care, Cigna-HealthSpring will approve the request or issue a Notice of Denial of Medical Coverage (NDMC) if the request is not medically necessary. Cigna-HealthSpring will also issue a NDMC if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the members' or their Representatives' right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

Cigna-HealthSpring also issues written Notice of Medicare Non-Coverage (NOMNC) determinations in accordance with CMS guidelines. This notice will be sent by fax to the SNF or HHA. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is requested and expected to fax a copy of the signed NOMNC back to Health Services at the number provided. The NOMNC includes information on members' rights to file a fast track appeal.

Readmission

The Health Services Department will review all readmissions occurring within 31 days following discharge from the same facility, according to established processes, to assure services are medically reasonable and necessary, with the goal of high quality cost effective health care services for Health Plan members.

The Health Services Utilization Management (UM) staff will review acute Inpatient and Observation readmissions. If admissions are determined to be related; they may follow the established processes to combine the two confinements.

The Role of the Cigna-HealthSpring ACCM (Acute Care Case Manager)

Cigna-HealthSpring Acute Care Case Managers (ACCMs) are registered nurses. All ACCMs are expected to perform at the height of their license. They understand Cigna-HealthSpring plan benefits and utilize good clinical judgment to ensure the best outcome for the member.

The Cigna-HealthSpring Acute Care Case Manager has two major functions:

- Ensure the member is at the appropriate level of care, in the appropriate setting, at the appropriate time through utilization review
- Effectively manage care transitions and length of stay (LOS)

Utilization review is performed utilizing evidence-based guidelines (Interqual) and collaborating with Primary Care Physicians (PCP), attending physicians and Cigna-HealthSpring medical directors.

The ACCM effectively manages all transitions of care through accurate discharge planning and collaboration with facility personnel to prevent unplanned transitions and readmissions via interventions such as:

- Medication Reconciliation
- Referral of members to Cigna-HealthSpring programs such as: CHF CCIP Program, Respiratory Care Program and Fragile Fracture Program
- Appropriate coordination of member benefits
- Obtaining needed authorizations for post-acute care services or medications
- Collaborating with attending physician and PCP, as needed
- Introducing and initiating CTI (Care Transition Intervention)
- Addressing STAR measures, as applicable: Hgb A1C & foot care, LDL, Colorectal Cancer Screening, Osteoporosis management in Women who had a fracture, Falls, Emotional Health, Flu & Pneumonia Vaccines and medication adherence
- Facilitating communication of care level changes to all parties

- The goals of the Cigna-HealthSpring ACCM are aligned with the goals of acute care facilities:
- Members/Patients receive the appropriate care, at the appropriate time, and in the most appropriate setting
- Readmissions are reduced and LOS is managed effectively

At Cigna-HealthSpring, we strive for Primary Care Physicians (PCP), attending physicians, and acute care facility personnel to view the Cigna-HealthSpring ACCM as a trusted resource and partner in the care of our members (your patients).

Discharge Planning/Acute Care Management

Discharge Planning is a critical component of the process that begins with an early assessment of the member's potential discharge care needs in order to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the member and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. Cigna-HealthSpring's Concurrent Review staff will coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan. The Acute Care Managers (ACM) Concurrent Review nurse will facilitate the communication for all needed authorizations for services, equipment and skilled services upon discharge.

In designated contracted facilities, Cigna-HealthSpring also employs ACMs to assist with the process, review the inpatient medical record and complete face-to-face member interviews to identify members at risk for readmission, in need of post-discharge complex care coordination and to aid the transition of care process. This process is completed in collaboration with the facility discharge planning and acute care management team members and other Cigna-HealthSpring staff. When permissible by facility agreement, the ACM also completes the concurrent review process onsite at assigned hospitals. The role of the ACM onsite reviewer then also includes the day to day functions of the concurrent review process at the assigned hospital by conducting timely and consistent reviews and discussing with a Cigna-HealthSpring medical director as appropriate. The reviewer monitors the utilization of inpatient member confinement at the assigned hospitals by gathering clinical information in accordance with hospital rules and contracting requirements including timelines for decision making. All clinical information is evaluated utilizing a nationally accepted review criteria.

The ACM onsite reviewer will identify discharge planning needs and be proactively involved by interacting with attending physicians and hospital case managers in an effort to facilitate appropriate and timely discharge. The onsite reviewer will follow the policies and procedures consistent with the guidelines set forth by Cigna-HealthSpring Services Department and the facility.

Adverse Determinations

Rendering of Adverse Determinations (Denials)

The Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits or eligibility.

Every effort is made to obtain all necessary information, including pertinent clinical information from the treating provider to allow the Medical Director to make appropriate determinations.

Only a Cigna-HealthSpring Medical Director may render an adverse determination (denial) based on medical necessity but he/she may also make a decision based on administrative guidelines. The Medical Director, in making the initial decision, may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, Cigna-HealthSpring notifies the facility or provider's office of the denial of service. Such notice is issued to the provider and the member, when applicable, documenting the original request that was denied and the alternative approved service, along with the process for appeal.

Cigna-HealthSpring employees are not compensated for denial of services. The PCP or Attending Physician may contact the Medical Director by telephone to discuss adverse determinations.

Notification of Adverse Determinations (Denials)

The reason for each denial, including the specific utilization review criteria with pertinent subset/information or benefits provision used in the determination of the denial, is included in the written notification and sent to the provider and/or member as applicable. Written notifications are sent in accordance with CMS and NCQA requirements to the provider and/or member as follows:

- For non-urgent pre-service decisions – within 14 calendar days of the request. For urgent pre-service decisions - *within 72 hours or three calendar days of the request
- For urgent concurrent decisions – *within 24 hours of the request
- For post-service decisions – within 30 calendar days of the request

***Denotes initial oral notification of the denial decision is provided with electronic or written notification given no later than 3 calendar days after the oral notification**

Peer-to-Peer information is provided.

Cigna-HealthSpring complies with CMS requirements for written notifications to members, including rights to appeal and grievances. For urgent care requests, Cigna-HealthSpring notifies the provider(s) only of the decision since the treating or attending practitioner is acting as the member's representative. If the denial is either concurrent or postservice (retrospective) and the member is not at financial risk, the member is not routinely notified.

Clinical Practice Guidelines & Reference Material

Cigna-HealthSpring has adopted evidence based clinical practice guidelines as roadmaps for healthcare decision-making targeting specific clinical circumstances. Cigna-HealthSpring promotes the use of clinical practice guidelines to:

- Define clear goals of care based on the best available scientific evidence;
- Reduce variation in care and outcomes;
- Provide a more rational basis for clinical management of some conditions;
- Comply with accreditation standards and regulatory expectations.

The table on page 111 contains the clinical practice guidelines approved by Cigna-HealthSpring's Clinical Policy Committee. The table also contains links to the Web sites with the most current version of the guideline.

This information is provided for general reference and not intended to address every clinical situation associated with the conditions and diseases addressed by these guidelines. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual patients. We hope you will consider this information and use it, when it is appropriate for your eligible members.

REFERRAL PROCESS

The Primary Care Physician (PCP) is the member's primary point of entry into the health care delivery system for all outpatient specialist care.

The PCP is required to obtain a referral for most outpatient specialist visits for Cigna-HealthSpring members.

Referrals can be requested through several methods, such as:

- IVR
- Fax
- Phone
- HS Connect

Your Network Operations representative can provide additional details regarding preferred method of communication in your area. Likewise, the specialist is required to ensure that a referral is in place prior to scheduling a visit (except urgent/emergent visits, which do not require referral). The specialist is also required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment and the need for any ongoing care.

Electronic submission/retrieval of referrals through HSConnect helps to ensure accurate and timely processing of referrals.

Referral Guidelines

- PCPs should refer only to Cigna-HealthSpring participating specialists for outpatient visits.
- Non-participating specialist's visits require prior authorization by Cigna-HealthSpring
- Referrals must be obtained PRIOR to specialist services being rendered
- PCPs should not issue retroactive referrals
- Most referrals are valid for 180 days starting from the issue date
- All requests for referrals must include the following information:
  - Member Name , Date of Birth, Member ID
  - PCP Name
  - Specialist Name
  - Date of Referral
  - Number of visits requested

If a member is in an active course of treatment with a specialist at the time of enrollment, Cigna-HealthSpring will evaluate requests for continuity of care. A PCP referral is not required, but an authorization must be obtained from Cigna-HealthSpring's Prior Authorization Department. For further details, please refer to the Continuity of Care section in Health Services.

Please note: A specialist may not refer the patient directly to another specialist. If a patient needs care from another specialist, he/she must obtain the referral from his/her PCP.

Self Referrals

Members have open access to certain specialists, known as self-referred visits/ services; these include but are not limited to:

- Emergency medicine (emergency care as defined in the provider contract)

- Obstetric and Gynecological care (routine care, family planning)
- Psychiatrist, Psychologist, Licensed Clinical Social Worker (behavioral health participating providers)

CASE MANAGEMENT SERVICES

The Cigna-HealthSpring Management Program is an administrative and clinically proactive process that focuses on coordination of services for members with multiple comorbidities, complex care needs and/or short term requirements for care. The Program is designed to work as a partnership between members, providers, and other health services staff. The goal is to provide the best clinical outcomes for members. The central concept is early identification, education, and measurement of compliance with standards of care. The case management staff strives to enhance the member's quality of life, facilitates provision of services in the appropriate setting, and promotes quality cost effective outcomes. Staff members with specific clinical expertise provide support services and coordination of care in conjunction with the treating provider.

Case Management Program Goals

Cigna-HealthSpring has published and actively maintains a detailed set of Program objectives available upon request in our case management program description. These objectives are clearly stated, measurable, and have associated internal and external benchmarks against which progress is assessed and evaluated throughout the year. Plan demographic and epidemiologic data, and survey data are used to select Program objectives, activities, and evaluations.

Case Management Approach

Cigna-HealthSpring has multiple programs in place to promote continuity and coordination of care, remove barriers to care, prevent complications and improve member quality of life. It is important to note that Cigna-HealthSpring treats disease management as a component of the case management continuum, as opposed to a separate and distinct activity. In so doing, we are able to seamlessly manage cases across the care continuum using integrated staffing, content, data resources, risk identification algorithms, and computer applications.

Cigna-HealthSpring employs a segmented and individualized case management approach that focuses on identifying, prioritizing, and triaging cases effectively and efficiently. Our aim is to assess the needs of individual members, to secure their agreement to participate, and to match the scope and intensity of our services to their needs. Results from health risk assessment surveys, eligibility data, retrospective claims data, and diagnostic values are combined using proprietary rules, and used to identify and stratify members for case management intervention. The plan uses a streamlined operational approach to identify and prioritize member outreach, and focuses on working closely with members and family/caregivers to close key gaps in education, self-management, and available resources. Personalized case management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target member groups.

Members are discharged from active case management under specific circumstances which many include stabilization of symptoms or a plateau in disease processes, the completed course of therapy, member specific goals obtained; or the member has been referred to Hospice. A member's case may be re-initiated based on the identification of a transition in care, a change in risk score, or through a referral to case management.

How To Use Services

Members that may benefit from case identified from multiple areas including utilization management activities, predictive modeling, and direct referrals from a provider. If you would like to refer a Cigna-HealthSpring member for Case Management services, please call **1-888-615-2709**. In addition, our members have access to information regarding the program via a brochure and website and may self refer. Members are contacted by our case management staff by telephone or face to face encounter. The member has the right to opt out of the program. If the member opts in, a letter will be sent to the member and you as the provider. Once enrolled, an assessment is completed with the member and a plan of care with goals, interventions, and needs is established.

Coordination with Network Providers

Cigna-HealthSpring offers members access to a contracted network of facilities, primary care and specialty care physicians, behavioral health, mental health, and alcohol and substance abuse specialists, as well an ancillary care network. Each member receives a provider directory annually giving in-depth information about how to find network providers in their area (by zip code and by specialty), how to select a PCP, conditions under which out-of-area and out-of-network providers may be seen, and procedures for when the member's provider leaves the network. A toll-free Customer Service telephone number is provided, and members with questions are asked to reach out to the plan. Members also have access to a series of web-based provider materials. The website allows members to search the provider directory for doctors, facilities, and pharmacies.

The provider is a key member of the Interdisciplinary care team. Our case management staff will work with you and your staff to meet the unique needs of each member.

Case managers work with members and providers to schedule and prepare for member visits, to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any non-clinical barriers to care. In cases where provider referrals are necessitated, case managers work closely with members to identify appropriate providers, schedule visits, and secure transportation. The plan also has a provider incentive program that supports case management objectives and which incentivizes providers to coordinate closely with the member and plan on specified quality measures.

Members of our Special Needs Plan have a defined Model of Care (See Model of Care Section) that includes Provider Training. Our case management program includes initiatives specific to this population and our case managers provide support to resolve the special needs of this population. As a provider, the need to coordinate benefits available from Medicare and Medicaid may occur with our Special Needs Program members. Our Summary of Benefits available on our website defines the benefits for your state and the case management staff can assist with identifying resources and providing support to assure coordination.

Communications

Cigna-HealthSpring provides multiple communication channels to members. The plan maintains a full-service inbound call program that allows members to inquire about all aspects of their relationship with the plan. Outbound member services and care management calls are also made regularly to members to encourage them to participate in clinical programs and assessment activities provided as part of their health care benefit. In addition to telephonic touch points, the plan regularly sends educational materials to members in response to identified care gaps and changes in health status. Members also have access to web-based materials, where they can learn more about their benefits, explore additional benefits, search the provider directory, find a pharmacy, query the formulary, and identify the time and location of sales sessions.

Program Evaluation

Cigna-HealthSpring continually monitors the Program, and makes changes as needed to its structure, content, methods, and staffing. Changes to the Program are made under two conditions: (1) changes must benefit members; and (2) changes must be in compliance with applicable regulations and guidance. Changes to the Program are accompanied by policy and procedure revisions and staff training as required. The Program operates under the umbrella of the plan's Quality Improvement Committee which reports to the Corporate Quality Improvement Committee. It is reviewed and updated annually in collaboration with the Quality Improvement Department. The plan's Physician Advisory Committee made up of network providers, also reviews the Program and its clinical guidelines at certain intervals and provides improvement recommendations.

Confidentiality

Cigna-HealthSpring is committed to preserving the confidentiality of its members and practitioners. Written policies and procedures are in place to ensure the confidentiality of member information. Patient data gathered during the case management process are available for the purposes of review only and are maintained in a confidential manner. Employees receive confidentiality training that includes appropriate storage and disposal of confidential information. Employees also sign a confidentiality agreement at the time of their initial company orientation.

Continuity of Care

Cigna-HealthSpring's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a practitioner leaves Cigna-HealthSpring's network and a member is in an active course of treatment, our Health Services staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. Members in their second or third trimester of pregnancy have access to the exiting provider through the postpartum period.

If the Plan terminates a participating provider, Cigna-HealthSpring will work to transition a member into care with a Participating Physician or other provider within Cigna-HealthSpring's network. Cigna-HealthSpring is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Cigna-HealthSpring also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in Cigna-HealthSpring's network. Under these circumstances, Cigna-HealthSpring will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

Cigna-HealthSpring will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other

on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at **1-800-453-4464**.

SPECIAL NEEDS PLAN - MODEL OF CARE

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special healthcare needs.

The three specific groups are:

- "Dual eligible" beneficiaries (individuals who are eligible for both Medicaid & Medicare);
- Individuals with Chronic conditions; and
- Individuals who are residents of long term care facilities or require that level of care and reside in the community.

In 2008, CMS issued the final regulation "Medicare Improvements for Patients and Providers Act of 2008," known as "MIPPA." This regulation mandated that all Special Needs Plans have a filed and approved Model of Care by January 1, 2010.

The Model of Care is an evidenced-based process by which we integrate benefits and coordinate care for members enrolled in Cigna-HealthSpring's Special Needs Plans. The Model of Care facilitates the early assessment and identification of health risks and major changes in the health status of members with complex care needs as well as the coordination of care to improve their overall health.

Cigna-HealthSpring's Special Needs Plan Model of Care has the following goals:

- Improve access to medical, mental health, and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact;
- Improve transitions of care across healthcare settings and providers;
- Improve access to preventive health services;
- Assure appropriate utilization of services; and
- Improve beneficiary health outcomes.

Importantly, the Model of Care focuses on the individual SNP member. SNP members receive a health risk assessment within 90 days of enrollment and annually thereafter. Based on the results of this assessment, an individualized care plan is developed using evidence-based clinical protocols.

All SNP members must have an individualized care plan. An interdisciplinary care team, which includes PCPs and practitioners of various disciplines and specialties, based on the needs of the member, is responsible for care management and supports the assessment and care planning process. The member may participate in this process, as may all healthcare providers. The individualized care plan is recorded centrally so that it may be shared with all members of the interdisciplinary care team, as indicated. All providers are encouraged to participate in the SNP Model of Care and interdisciplinary care teams.

Cigna-HealthSpring uses a data-driven process for identifying the frail/disabled, multiple chronic illnesses and those at the end of life. Risk stratification and protocols for intervention around care coordination, barriers to care, primary care givers, education, early detection, and symptom management are also components of the Model of Care. Based on the needs of plan members, a specialized provider network is available to assure appropriate access to care, complementing each member's primary care provider.

Execution of the Model of Care is supported by systems and processes to share information between the health plan, healthcare providers and the member. The SNP Model of Care includes periodic analysis of effectiveness, and all activities are supported by the Quality Improvement Program.

For Dual SNP members:

Providers may contact our Health Risk Assessment department to request patients' HRA results at **1-800-331-6769**.

To discuss and/or request a copy of a patient's care plan, refer a patient for an Interdisciplinary Care Team meeting or participate in an Interdisciplinary Care Team meeting, please contact our Case Management department at **1-888-615-2709**, ext. 2714.

REFERRAL PROCESS

The IVR system is set up with a default of six (6) visits per one hundred eighty (180) days for all referrals, with these exceptions, for which you will be transferred to a Referral Specialist: Chemotherapy, Allergy, Mental/Chemical Dependency. You will need to press the # key after any time a UPIN, Member number, or ICD-9 code is entered.

Remember: An authorization number does not guarantee payment – services must be a covered benefit. To verify benefits before providing services, call **1-800-453-4464** option 1.

New Referral Entry – Access the System

- Dial **1-888-583-3345**, listen to the introductory prompt.
- Enter the Member number
- Enter the Provider number (use associated keypad number for first letter – use 0 for letters Q and Z). **Note:** system may request provider relationship – press 1 for PCP and press 2 for specialist).
- New Referral, press 1.

New Referral Entry – Enter New Referral

- Enter specialist UPIN (use associated keypad number for first letter – use 0 for letters Q and Z).
- Enter ICD-9 (use * for period).
- Press # key.
- System will repeat ICD-9: Press 1 if correct, press 2 to re-enter.
- System will summarize referral date.
- Press 1 to confirm referral or press 2 to cancel referral.
- Referral number will be issued by the system.
- Proceed with one of the following actions:
  - Press 1 – New referral, same
  - patient, same PCP
  - New referral, different patient, same PCP
  - Update existing referral, same PCP
  - Press 2 – New referral, different patient, different PCP
  - Press 3 – Repeat referral number
  - Press # – Disconnect

Existing Referral Questions – Access the System

1. Dial **1-888-583-3345**, listen to the introductory prompt.
2. Enter the Member number
3. Enter the Provider number (use associated keypad number for first letter – use 0 for letters Q and Z). Note: system may request provider relationship – press 1 for PCP and press 2 for specialist).
4. Update existing referral, press

Existing Referral Questions

1. Press 2 for questions regarding an existing referral.
2. System will transfer to Referral Specialist.

Referral Inquiry – Access the System

1. Dial **1-888-583-334**5, listen to the introductory prompt.
2. Enter the Member number

Make the Inquiry

1. Enter the specialist's Provider number (use associated keypad number for first letter – use 0 for letters Q and Z).
2. If referral is on file, the system will summarize associated data or if the referral is not on file, the system will report "no open referral".
3. Proceed with one of the following actions:
   - Press 1 – New inquiry, different member
   - Press 2 – Disconnect

Self Referral

Please refer to Cigna-HealthSpring's website to view the current provider directory for Participating Specialists. If a member has a preference, the PCP should accommodate this request if possible. The only exceptions where the member may self refer are:

- To a Participating Gynecologist for annual gynecological exam except for infertility and to see a non-participating OB/GYN. The PCP may perform the annual exam if agreed upon by the member.
- Behavioral health referrals to Cigna-HealthSpring's Behavioral Health Care
- Vision Exams – Members who have a Vision benefit may self refer to a participating provider
- Dental Coverage – Members who have a Dental benefit may self refer to a Participating Dental provider

Referral Process

All referrals must be obtained prior to services being rendered. No retro-authorizations of referrals will be accepted. Please note that we value the PCP's role in taking care of our Cigna-HealthSpring members and that the PCP has a very important role in directing the member to the appropriate specialist based on your knowledge of the patient's condition and health history. It is also absolutely essential that members are directed to participating providers only. In order to ensure this, please refer to our online directory or contact Customer Service for assistance

Primary Care Physician's Referral Responsibilities

A PCP is responsible for ensuring a member has a referral prior to the appointment with the specialist.

There are four ways a PCP can obtain referral to specialists:

1. **Interactive Voice Response Unit (IVR):** The IVR is a telephonic system which allows you to enter a referral directly into our system. The IVR is available from 6 a.m. to 9 p.m. CST. The

IVR can be accessed by dialing **1-888-583-3345**. If you need assistance, the IVR technical support phone number is **1-800-453-4464**, Monday-Friday, 8am-5pm (central).

2. **Referral Form:** Complete the referral form and fax it into our referral department.
3. **Referral Log:** If the referral to a specialist is not needed within the next forty-eight (48) hours, you may fax the referral log to us on a weekly basis.
4. **Call in to the Referral Department:** If the referral is an emergency, you are not able to access the IVR, or you simply would like to speak with a referral department representative, you may obtain a referral by phone by calling **1-800-453-4464**.

Specialist Physician's Referral Responsibilities

Specialists must have a referral from a PCP prior to seeing a member if the member's plan requires a referral. Claims will be denied if a specialist sees a member without a referral when the health plan requires a referral. Cigna-HealthSpring is unable to make exceptions to this requirement. If a referral is not in place, specialists must contact the member's PCP before the office visit. In order to verify that a referral has been made, the specialist may access the IVR by dialing **1-888-583-3345** and entering the following components:

- Member's identification number
- ICD-9 code
- PCP's UPIN/NPI number
- Specialist's UPIN/NPI number
- Or, the specialist may call Cigna-HealthSpring to verify.

Instructions for a Specialist to Obtain Referrals:

The specialist can obtain referrals directly for the member to another Specialist with the following limits:

1. The PCP referred the member to the specialist
2. The following four (4) conditions must be met:
   - Diagnosis must be related to the specialty and/or service to be obtained
   - Diagnosis must be related to reason PCP referred to referring Specialist.
   - Must be a covered benefit of the health plan
   - The member must be currently under the care of the referring specialist
   - Referral must be made to a participating provider
3. The specialist provides follow-up documentation to the PCP for all referrals obtained for further specialty care
4. Referrals for the following specialty care are excluded from this process and must be referred back to the PCP to obtain referral: Non-participating providers, Chiropractor, Dermatology, Otolaryngology, Maxillofacial Surgeon, Podiatry, Optometry, Transplant Specialist, and Reconstructive (Plastic) Surgeon with the exception of breast reconstruction.
5. The referral must be obtained prior to the services being rendered.

Note: If all elements within the limits above cannot be met, the specialist must defer back to the PCP for further services.

The specialist may obtain referrals via fax or IVR. Specialist should use the fax method if the referral is not needed within forty-eight (48) hours. If the referral is needed in less than forty-eight (48) hours, the specialist must use either the telephone referral process or the IVR.

CIGNA HOME DELIVERY PHARMACY

One of the most important ways to improve the health of your patients is to make sure they receive and take their medications as you prescribe. Cigna Home Delivery Pharmacy can help. Our customers have 20% higher adherence rates when compared to those who use retail pharmacies alone.[1] We send a three month supply in one fill making it easier for your patient by only having to fill four times a year – many times at a lower cost. Lastly, our customers have access to our QuickFill service which sends automatic reminders via email, phone or SMS text message making it easier for patients to refill their prescriptions so they don't miss a dose. Talk to your patients today about Cigna Home Delivery Pharmacy for better health and health care spending. Doctors and staff can reach us at **1-800-285-4812** (option 3) or fax prescriptions to **1-800-973-7150**.

[1] Cigna Analysis, 2011

QUALITY MANAGEMENT PROGRAM

Overview

Quality Management Program Principles for Cigna-HealthSpring:

1. Provide services that are clinically driven, cost effective, and outcome oriented;
2. Provide services that are culturally informed, sensitive, and responsive;
3. Provide services that enable members to live in the least restrictive, most integrated community setting appropriate to meet their health care needs;
4. Ensure that guidelines and criteria are based on professional standards and evidence-based practices that are adapted to account for regional, rural, and urban differences;
5. Foster an environment of quality of care and service within Cigna-HealthSpring and through our Provider Partners; and
6. Promote member safety as an overriding consideration in decision making.

Cigna-HealthSpring is committed to providing access to quality health care for all members in all product lines through the continuous planning, implementation, assessment to improve the quality of care and services to our members. The Quality Management Program assumes that there is no permanent threshold for good performance. Our members expect and should be provided a comprehensive and therapeutic health care delivery system that is always evolving and improving.

The Quality Management Program accomplishes this by integrating, analyzing, and reporting on data from across the Plan as well as other data sources. The Quality Management Program prioritizes quality initiatives based on relevance to the population Cigna-HealthSpring serves, and works with other departments to manage plan resources in the most cost effective manner to maximize patient health outcomes. The following is a brief overview of the Quality Management Program's functions.

- Collects and investigates internal and external reporting of quality of care concerns. Substantial quality concerns are presented to the Quality Improvement Committee (QIC) to formulate corrective action plans and monitor the results.
- Coordinates and facilitates Quality Improvement activities. The QIC is charged with providing oversight (identification, prioritization, and coordination) of all quality improvement activities related to the care and services provided to our members.
- Coordinates with various internal departments in preparation for mandatory Centers for Medicare and Medicaid Services (CMS) and state activities, such as Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Health Outcomes Survey (HOS).
- Works to encourage optimal health outcomes for our members through annual review of best practice standards. Preventive standards are leveraged from The United States Preventive Services Task Force Standards (USPSTF), which standards are derived from the American Diabetes Association, the American Cancer Society as well as other nationally recognized organizations. Guidelines for preventive and chronic care are revised and modified to reflect the latest in clinical best practices.

If you have any questions about Cigna-HealthSpring's Quality Management Program or would like a comprehensive description of the Program, its Annual Goals, or a list of activities toward achieving those goals, please feel free to contact Customer Service. Information will be provided upon request.

Quality Management Program

Goal: To assure timely access to and availability of appropriate quality services for the population served by Cigna-HealthSpring.

- **Objective:** Ensure services are provided by qualified individuals and organizations including those with the qualifications and experience appropriate to service members with special needs especially those residing in a community setting at a long term care level of care.
- **Objective:** Ensure the safety of all members in all treatment settings.
- **Objective:** Improve the health service delivery system by implementing procedures and policies to conduct access, availability, quality, utilization, care coordination, credentialing, compliance, and fiscal monitoring using defined standards.
- **Objective:** Improve the medical and behavioral health of individuals served by Cigna-HealthSpring.

Goal: To encourage and mentor provider and plan staff in the implementation of the Quality Management Program and methods to ensure compliance with Cigna-HealthSpring policies, procedures and standards, and to support a provider and community culture of quality improvement.

- **Objective:** Improve the ability of all Cigna-HealthSpring staff to apply quality methodology through a program of education, training, and mentoring.

- **Objective:** Improve performance measures tied to provider reimbursement.
- **Objective:** Improve member and provider satisfaction.
- **Objective:** Ensure adequate infrastructure and resources to support the Quality Management Program.

Goal: To assure community involvement in maintaining and improving the health of Cigna-HealthSpring members, through a comprehensive community/provider partnership.

- **Objective:** Improve the quality of all activities through the education of staff, providers, members, and the community in best practices/evidence-based practices.
- **Objective:** Improve the level of customer service and communication both internal and external.
- **Objective:** Improve the coordination and collaboration of care among providers, and between Cigna-HealthSpring and providers, especially between physical and behavioral health providers.

Goal: Improve Health Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Provider Satisfaction scores and utilize these measures throughout the organization as quality outcomes.

Quality Improvement Committee (QIC)

The QIC is responsible for the overall design and implementation of quality improvement activities for the Cigna-HealthSpring organization, as well as for the oversight of quality improvement activities carried out by other quality sub-committees. The QIC reports these activities to the Board of Directors. The QIC ensures that member and provider feedback and recommendations are used when designing activities to improve care and services.

CORPORATE COMPLIANCE PROGRAM

Overview

The purpose of Cigna-HealthSpring's Corporate Compliance Program is to articulate Cigna-HealthSpring's commitment to compliance. It also serves to encourage our employees, contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Cigna-HealthSpring's operations. Further, Cigna-HealthSpring's Corporate Compliance Program also ensures that all practices and programs are conducted in compliance with those applicable laws and regulations.

Cigna-HealthSpring and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Cigna-HealthSpring's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members. Cigna-HealthSpring and its employees are also committed to meeting all contractual obligations set forth in Cigna-HealthSpring's contracts with the Centers for Medicare and Medicaid Services (CMS). These contracts allow Cigna-HealthSpring to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing Cigna-HealthSpring's lines of business, including but not limited to, health care fraud and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and, when necessary, disclosure to the appropriate governmental authorities.

Cigna-HealthSpring has in place policies and procedures for coordinating and cooperating with MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement. Cigna-HealthSpring also has policies that delineate that Cigna-HealthSpring will cooperate with any audits conducted by CMS, MEDIC or law enforcement or their designees.

Fraud, Waste, and Abuse

Cigna-HealthSpring has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network to properly recover such overpayments. These procedures allow us to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at42 C.F.R. § 422.503(b)(4)(vi) and 42 C.F.R. § 423.504(b)(4)(vi)(H), and Cigna-HealthSpring has policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by Cigna-HealthSpring encompasses all aspects of Cigna-HealthSpring's business and its business relationship with third parties, including health care providers and members. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith.

Reports may be filed in the following manner:

To report suspected or detected Medicare program non-compliance please contact Cigna-HealthSpring's Compliance Department at:

- **Cigna-HealthSpring**
  Attn: Compliance Department
  9009 Carothers Parkway, Suite B-100
  Franklin, TN 37067

To report potential fraud, waste, or abuse please contact Cigna-HealthSpring's Benefit Integrity Unit at:

- By mail:
  - **Cigna-HealthSpring**
    Attn: Benefit Integrity Unit
    500 Great Circle Road
    Nashville, TN 37228
- By phone:
  - **1-800-230-6138**
    Monday through Friday, 8 a.m. to 6 p.m. CST

All such communications will be kept as confidential as possible but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or other party that reports compliance concerns in good faith can do so without fear of retaliation.

In addition, as part of an ongoing effort to improve the delivery and affordability of health care to our members, Cigna-HealthSpring conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9 and HCPCS, codes billed by our providers. The analysis allows Cigna-HealthSpring to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. Cigna-HealthSpring will review your coding and may review medical records of providers who continue to show significant variance from their peers. Cigna-HealthSpring endeavors to ensure compliance and enhance the quality of claims data, a benefit to both Cigna-HealthSpring's medical management efforts and our provider community. As a result, you may be contacted by Cigna-HealthSpring's contracted partners to provide medical records to conduct reviews to substantiate coding and billing.

In order to meet your FWA obligations, please take the following steps:

Review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.

Complete the mandatory online training at:

- **https://cms.meridianksi.com/kc/main/pop_up_frm.asp?loc=/kc/ilc/course_info_enroll_info.asp%3Fpreview%3DFalse%26crs_ident%3DC200%%2Cheight%3D100&strTable=undefined&strContentID=undefined**

You may request a copy of the Cigna-HealthSpring Compliance Program document by contacting your Cigna-HealthSpring Provider Relationship Representative.

MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The terms and conditions herein are included to meet federal statutory and regulatory requirements of the federal Medicare Advantage Program under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program"). provider understands that the specific terms as set forth herein are subject to amendment in accordance with federal statutory and regulatory changes to the Medicare Advantage Program. Such amendment shall not require the consent of provider or Cigna-HealthSpring and will be effective immediately on the effective date thereof.

1. **Books and Records; Governmental Audits and Inspections**. Provider shall permit the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to provider's performance of the Agreement and transactions related to the CMS Contract (collectively, "Records"). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit provider's Records for any particular contract period under the CMS Contract shall exist for a period of ten (10) years from the later to occur of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the "Audit Period"). Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.
2. **Privacy and Confidentiality Safeguards.** Provider shall safeguard the privacy and confidentiality of members and shall ensure the accuracy of the health records of members. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription

records) of members, including, but not limited, to the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.

3. **Member Hold Harmless.** Provider shall not, in any event (including, without limitation, non-payment by Cigna-HealthSpring or breach of the Agreement), bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from or hold responsible, in any respect, any member for any amount(s) that Cigna-HealthSpring may owe to provider for services performed by provider under the Agreement. This provision shall not prohibit provider from collecting supplemental charges, co-payments or deductibles specified in the Benefit Plans. Provider agrees that this provision shall be construed for the benefit of the member and shall survive expiration, non-renewal or termination of the Agreement regardless of the cause for termination.

4. **Delegation of Activities or Responsibilities.** To the extent activities or responsibilities under a CMS Contract are delegated to provider pursuant to the Agreement ("Delegated Activities"), provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Cigna-HealthSpring; and (ii) in the event that the Cigna-HealthSpring or CMS determine that provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable State and/or Federal laws and regulations and CMS instructions, then Cigna-HealthSpring shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Cigna-HealthSpring. To the extent that the Delegated Activities include professional credentialing services, provider agrees that the credentials of medical professionals affiliated or contracted with provider will either be (i) directly reviewed by Cigna-HealthSpring, or (ii) provider's credentialing process will be reviewed and approved by Cigna-HealthSpring and Cigna-HealthSpring shall audit provider's credentialing process on an ongoing basis. Provider acknowledges that Cigna-HealthSpring retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals. In addition, provider understands and agrees that Cigna-HealthSpring maintains ultimate accountability under its Medicare Advantage contract with CMS. Nothing in this Agreement shall be construed to in any way limit Cigna-HealthSpring's authority or responsibility to comply with applicable regulatory requirements.

5. **Prompt Payment.** Cigna-HealthSpring agrees to pay provider in compliance with applicable state or federal law following its receipt of a "clean claim" for services provided to Cigna-HealthSpring members. For purposes of this provision, a clean claim shall mean a claim for provider services that has no defect or impropriety requiring special treatment that prevents timely payment by Cigna-HealthSpring.

6. **Compliance with Cigna-HealthSpring's Obligations, Provider Manual, Policies and Procedures.** Provider shall perform all services under the Agreement in a manner that is consistent and compliant with Cigna-HealthSpring's contract(s) with CMS (the "CMS Contract"). Additionally, provider agrees to comply with the Cigna-HealthSpring Provider Manual and all policies and procedures relating to the Benefit Plans.

7. **Subcontracting.** Cigna-HealthSpring maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of Cigna-HealthSpring. Every subcontract between provider and a subcontractor shall (i) be in writing and comply with all applicable local, State and federal laws and regulations; (ii) be consistent with the terms and conditions of this Agreement; (iii) contain Cigna-HealthSpring and member hold harmless language as set forth in Section 3 hereof; (iv) contain a provision allowing Cigna-HealthSpring and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by provider to subcontractor under such subcontract; and (v) be terminable with respect to members or Benefit Plans upon request of Cigna-HealthSpring.

8. **Compliance with Laws.** Provider shall comply with all State and Federal laws, regulations and instructions applicable to provider's performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for provider to perform the services under the

Agreement. Without limiting the above, Provider shall comply with Federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).

9. **Program Integrity.** Provider represents and warrants that provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider shall notify Cigna-HealthSpring immediately if, at any time during the term of the Agreement, provider (or any of its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider acknowledges that provider's participation in Cigna-HealthSpring shall be terminated if provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services.
10. **Continuation of Benefits.** Provider shall continue to provide services under the Agreement to members in the event of (i) Cigna-HealthSpring's insolvency, (ii) Cigna-HealthSpring's discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to Cigna-HealthSpring, and, to the extent applicable, for members who are hospitalized, until such time as the member is appropriately discharged.
11. **Incorporation of Other Legal Requirements.** Any provisions now or hereafter required to be included in the Agreement by applicable Federal and/or State laws and regulations or by CMS shall be binding upon and enforceable against the parties to the Agreement and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this Manual or elsewhere in your Agreement.
12. **Conflicts.** In the event of a conflict between any specific provision of your Agreement and any specific provision of the Manual, the specific provisions of this Manual shall control.

DISPUTE RESOLUTION

Any controversy, dispute or claim arising out of or relating to your Provider Agreement ("Agreement") or the breach thereof, including any question regarding its interpretation, existence, validity or termination, that cannot be resolved informally, shall be resolved by arbitration in accordance with this Section, provided however that a legal proceeding brought by a third party against Cigna-HealthSpring, an Affiliate, provider, or any provider ("Defendant"), any cross-claim or third party claim by such Defendant against Cigna-HealthSpring, an Affiliate, provider, or any provider Facility shall not be subject to arbitration. In the event arbitration becomes necessary, such arbitration shall be initiated by either Party making a written demand for arbitration on the other Party. The arbitration shall be conducted in the county were the majority of the services are performed, in accordance with the Commercial Arbitration Rules of the American Arbitration Association, as they are in effect when the arbitration is conducted, and by an arbitrator knowledgeable in the health care industry. The Parties agree to be bound by the decision of the arbitrator. The Parties further agree that the costs, fees and expenses of arbitration will be borne by the non-prevailing party. Notwithstanding this Agreement to arbitrate, Cigna-HealthSpring, an Affiliate, provider, or any provider Facility may seek interim and/or permanent injunctive relief pursuant to this Agreement in the county were the majority of the services are performed in any court of competent jurisdiction. With respect to disputes arising during the life of this Agreement, this Section shall survive the termination or expiration of the Agreement.

APPENDIX

REVISED
TENNESSEE/NORTHERN GEORGIA/NORTHERN MISSISIPPI/EASTERN ARKANSAS
PRIOR AUTHORIZATION LIST
FOR DATES OF SERVICE ON OR AFTER JUNE 1, 2014

Prior Authorization (PA) Requirements
This Cigna-HealthSpring Prior Authorization list supersedes any lists that have been previously distributed or published–older lists are to be replaced with the latest version.

Cigna-HealthSpring Prior Authorization (PA) Policy
PCP's or referring providers should **OBTAIN** Prior Authorization BEFORE services requiring Prior Authorizations are rendered. Prior Authorizations may be obtained via HealthSpring Connect (HSC) or as otherwise indicated in the Health Services section of the 2014 Provider Manual. Please see the HealthSpring Connect section of the Provider Manual for an overview of the HSC portal capabilities and instructions for obtaining access.

Rendering Providers should **VERIFY** that a Prior Authorization has been granted **BEFORE** any service requiring a Prior Authorization is rendered. Prior Authorizations may be verified via HealthSpring Connect (HSC) or as otherwise indicated in the Health Services section of the Provider Manual.

IMPORTANT – Prior Authorization and/or Referral Number(s) is/are not a guarantee of benefits or payment at the time of service. Remember, benefits will vary between plans, so always verify benefits.

Cigna-HealthSpring Referral Policy
Cigna-HealthSpring values the PCP's role in directing the care of Members to the appropriate, participating Providers. Participating Specialists are contracted to work closely with our referring PCPs to enhance the quality and continuity of care provided to Cigna-HealthSpring Members.

Although a Prior Authorization may not be required for certain services, a REFERRAL from a PCP to a Specialist MUST BE in place. The Referral should indicate PCP approved for a consultation only or for consultation and treatment, including the number of PCP approved visits.

Refer to the online directory at www.cignahealthspring.com or contact **Provider Services, toll-free phone: (800) 230-6138** to locate an in-network provider.

Procedures/Services	PA Required	PA Not Required	Comments
Admissions	✓		**Inpatient Admission** ➡ **Yes**, Prior Auth required **Inpatient Observation** ➡ **Yes**, Prior Auth required **Inpatient Rehabilitation** ➡ **Yes**, Prior Auth required **Skilled Nursing Facility** ➡ **Yes**, Prior Auth required **LTAC** ➡ **Yes**, Prior Auth required **Intermediate Care Facility/Assisted Living** ➡ **Yes**, Prior Auth required
Allergy Injections without a MD visit		X	
Allergy Serum and Testing		X	No auth required with a Specialist referral
Ambulance (Air or Ground)	See Comments ➡		**Non-Emergent Transports** ➡ **Yes**, Prior Auth required **Emergent Transports** ➡ **No**, Prior Auth not required

Procedures/Services	PA Required	PA Not Required	Comments
Ambulance (Air or Ground) cont.	See Comments ➡		**Facility to Facility Transfer** ➡ **Yes**, Prior Auth required
Amniocentesis		✗	
Angioplasty/Cardiac Catheterization/ Stents (cardiac and renal)	✓		
Arteriogram/Angiogram	✓		
Audiogram		✗	
Biopsy		✗	
Blood Services (Outpatient)		✗	
Bone Density Study		✗	
Bronchoscopy		✗	
Cardiac Monitoring		✗	
Cardiac Rehab		✗	Only covered for specific conditions under Medicare guidelines
Cardiac Testing	✓		
Cardioversion		✗	
Chemotherapy	✓		Initial treatment only
Chiropractic	✓		Only covered for specific conditions under Medicare guidelines
CT Scans • Fast (EBCT) • 64 Slice • CTA Scans – all modalities	✓		Requests for authorization should be directed to MedSolutions for approval [1] www.medsolutionsonline.com or 888-693-3211
Diabetic Supplies and Monitors	✓		Prior Auth required if provided under Part B benefits
Doppler/Duplex Studies		✗	
Durable Medical Equipment (DME)	See Comments ➡		**Prior Authorization is Required For:** • All rental DME • Purchased DME **with billed charges, per line item, greater than $500;** certain items require Prior Auth regardless of price [2] • All supplies **with billed charges, per line item, greater than $500** • All repairs to DME
Echocardiogram (ECG) • Transthoracic Echo (TTE) • Transesophageal Echo (TEE) • Stress Echo	✓		Requests for authorization should be directed to MedSolutions for approval [1] www.medsolutionsonline.com or 888-693-3211
Electrocardiogram (EKG)		✗	
Electroencephalogram (EEG)		✗	
Electromyography (EMG)		✗	
Electrophysiology (EP)		✗	
Education		✗	Includes diabetic education, nutritional counseling, and smoking cessation
Endoscopy		✗	
Facility to Facility Transfers	✓		See ambulance
Genetic Testing	✓		Only covered under certain conditions under Medicare guidelines
Hemodialysis		✗	
Home Health Services	✓		
Home Infusion	✓		
Interventional Radiology	✓		
Lab work		✗	Must use contracted provider
MRA (all modalities)	✓		Requests for authorization should be directed to MedSolutions for approval [1] www.medsolutionsonline.com or 888-693-3211

Procedures/Services	PA Required	PA Not Required	Comments
MRI (all modalities)	✓		Requests for authorization should be directed to MedSolutions for approval [1] www.medsolutionsonline.com or 888-693-3211
Myelogram		✗	
Nuclear Cardiac Studies	✓		Requests for authorization should be directed to MedSolutions for approval [1] www.medsolutionsonline.com or 888-693-3211
Nuclear Radiology Studies	✓		
Occupational Therapy	✓		
Orthotics	See Comments →		**Prior Authorization is Required For:** • Purchased Orthotics **with billed charges, per line item, greater than $500** • All repairs to Orthotics
Outpatient Observation	✓		
Outpatient Surgical Procedures	✓		Outpatient hospital and ambulatory surgical centers require prior authorization
Oxygen Equipment	✓		
Part B Drugs	✓		
Peritoneal/Home Dialysis		✗	
Physical Therapy	✓		
Podiatry	✓		Only covered for specific conditions under Medicare guidelines
Positron Emission Tomography (PET)	✓		Requests for authorization should be directed to MedSolutions for approval [1] www.medsolutionsonline.com or 888-693-3211
Preventive Screenings		✗	Include mammogram, pap test, colonoscopy, flu and pneumonia vaccines, bone density, glaucoma screening
Prosthetics	See Comments →		**Prior Authorization is Required For:** • Purchased Prosthetics **with billed charges, per line item, greater than $500** • All repairs to Prosthetics
Pulmonary Rehab		✗	Only covered for specific conditions under Medicare guidelines
Radiation Therapy	✓		Prior Auth only required for IMRT, Gamma knife, and Cyber knife
Respiratory Therapy	See Comments →		**In home setting** → **Yes**, Prior Auth required **In hospital or outpatient setting** → **No**, Prior Auth **not** required
Sleep Study	See Comments →		**In home setting** → **Yes**, Prior Auth required **In hospital or outpatient setting** → **No**, Prior Auth **not** required
Specialty Services	✓		PCP Referral to Specialty Physician is required
Speech Therapy		✗	
Ultrasound		✗	
Wound Care (Physician Office or Outpatient Wound Center)	✓		
X-ray		✗	

1 MedSolutions Diagnostic Imaging Management Program will apply to membership in the following regions: ARIND, CHAT, CORE, DES, DKB, EME, ERL, GIND, HSTR, IND, IND9, JAX, KCOV, KMG, KSUM, KNOX, MEH, MEM, MEM9, MMT, MTHD, NME, NOR, NOR9, PER, RCP, SCI, SOU,STF, UCMB, VMG, and WTI. *The program* may or may not apply to IPA membership; please refer to your IPA directory for additional information.

2 DME requiring prior auth regardless of price – chest wall oscillation vest, conductive garment for TENS or NMES, cough stimulating device, cuirass chest shell, external defibrillator, gel pressure pad or non-powered pressure overlay for mattress, hydrocollator portable unit, implantable infusion pump, incontinent treatment system, pelvic floor stimulator, jaw motion rehab system, manual and power wheelchair cushions and accessories, osteogenesis stimulator, pneumatic compression device and/or any appliance to use with it, powered wheelchair or scooter, seat lift mechanism, shoulder flexion rotation device, speech generating device, TENS device, traction equipment

BEHAVIORAL HEALTH SERVICES QUICK FACTS AND PHONE GUIDE

Cigna-HealthSpring is committed to providing our members with the highest quality and greatest value in healthcare benefits and services. Managing the behavioral health benefits of our members allows Cigna-HealthSpring the opportunity to demonstrate this commitment by recognizing overall needs and providing better care.

Cigna-HealthSpring will continue to offer the outpatient services listed below without the requirement of a prior authorization. Any service not listed will continue to utilize the standard authorization process.

Services Requiring No Authorization by Participating Provider

CPT Code	DESCRIPTION	Report with Psychotherapy Add-On Codes
90791	Psychiatric diagnostic evaluation (no medical services)	
90792 (or New Patient E & M codes)	Psychiatric diagnostic evaluation with medical services	
Out Patient 99201-99205 99211-99215	New Patient Visit (10-60 min) Established Patient (5-25 min)	Psychotherapy Add On Codes: (when appropriate) 90833-30 min 90836-45 min 90838-60 min
Nursing Facility 99304-99306 99307-99310	New Patient Visit (10-45 min) Established Patient (10-35 min)	
90832	Psychotherapy (30 min)	
90834	Psychotherapy (45 min)	
90846	Family Psychotherapy (without patient present)	
90847	Family Psychotherapy (with patient present)	
90853	Group Psychotherapy (other than of a multiple–family group) *Physicians Office Only ~ Facilities Require Prior Authorization.*	
Q3014	Telehealth	

FUNCTION	PHONE/ADDRESS	DESCRIPTION OF SERVICES
Member Eligibility/Benefits	800-453-4464 **(*IVR)**	Verification of coverage and benefits; for facility admissions and other facility services, consult the Common Working File if member does present ID card.
Authorization Line	866-780-8546 Fax: 866-949-4846	Prior authorization is required for services not listed above.
Inpatient Admissions	866-780-8546 Fax: 866-949-4846	Notification is required within 24 hours of admissions; clinical staff available 24 hrs a day/7 days a week to assist with notifications and precertification.
Claims Submission (paper)	Cigna-HealthSpring Claims Dept P.O. Box 981804 El Paso, TX 79998-1706	
Claims Submission (electronic)	Clearing Houses: *Emdeon, *Relay Health, *Proxymed, *OfficeAlly * SSIGroup, * Availity **Payor ID #63092**	
Claim Status Inquires	800-453-4464 **(*IVR)**	
HSConnect	**www.cignahealthspring.com**	Access to on-line provider portal for verification of member eligibility, authorization, and claim payment review. Select Providers tab, then HSConnect to access portal.

***(IVR) Interactive Voice Response System**

Tennessee Department of Health
Division of Health Licensure and Regulation
Office of Health Care Facilities
227 French Landing, Suite 501
Heritage Place Metrocenter
Nashville, TN 37243
Telephone (615) 741-7221
Fax (615) 253-8798
www.tn.gov/health

ADVANCE CARE PLAN
(Tennessee)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (_____)_____ Relation: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (_____)_____ Relation: _____

Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one):

☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.

☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

   _____
   Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

   _____
   Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE

County of _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

Notary Public:_____
Signature

My commission expires:_____

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

PH-4194 RDA – n/a

ARKANSAS
Advance Directive
Planning for Important Health Care Decisions

Caring Connections
1731 King St,, Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Arkansas Declaration and Durable Power of Attorney for Health Care

This packet contains your **Arkansas Declaration and Durable Power of Attorney for Health Care**. This legal document protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Page 1 of your document contains your **Declaration**, which allows you to state your wishes about medical care in the event that you either: (1) develop a terminal condition and are unable to make your own medical decisions; or (2) are in a permanently unconscious state. The declaration becomes effective when you are in either of these states, your doctor and one other doctor has determined you are in such a state, and the declaration has been communicated to your doctor. Page 1 includes a space for you to include additional directions in the event you are terminally ill or permanently unconscious.

Pages 2 and 3 of your document contain your **Arkansas Durable Power of Attorney for Health Care**, which lets you name an **Agent** to make decisions about your medical care any time you lose the ability to make medical decisions for yourself. Page 3 of your document allows you to include directions in the event you lose the ability to make medical decisions for yourself. These directions are triggered any time you lose capacity, and are not dependent on you becoming terminally ill or permanently unconscious.

Your durable power of attorney for health care also appoints your agent as your **Health Care Proxy** to make decisions about your medical care — including decisions about life sustaining treatment — if you are terminally ill and can no longer make your own decisions about health care or are permanently unconscious.

Your durable power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Page 4 of your document is your signature page. Your signature must be witnessed by two people who are 18 years of age or older.

Note: This form authorizes mental health care decisions to be made by your agent/proxy, but does not go into detail regarding mental health issues. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney.

Following your Arkansas declaration and durable power of attorney for health care is an organ donation form.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Instructions for Completing Your Arkansas Declaration and Durable Power of Attorney

How do I make my Arkansas Declaration and Durable Power of Attorney for Health Care legal?

The law requires that you sign or someone signs at your direction on your behalf your Declaration and Durable Power of Attorney for Health in the presence of two witnesses, who must be 18 years of age or older.

Whom should I appoint as my Agent/Proxy?

Your agent/proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent/proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent/proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. **To avoid any confusion, you should name the same person as your agent/proxy in the Directive section as you name in the Durable Power of Attorney section.**

You can appoint a second person as your alternate agent/proxy. The alternate will step in if the first person you name as an agent/proxy is unable, unwilling, or unavailable to act for you.

Can I add personal instructions to my Declaration?

One of the strongest reasons for naming an agent/proxy is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent/proxy carry out your wishes, but be careful that you do not unintentionally restrict your agent/proxy's power to act in your best interest. In any event, be sure to talk with your agent/proxy about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke the instructions in your declaration at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective when you (or a witness to your revocation) notify your doctor or other health care provider, who must then make the revocation a part of your medical record.

You may revoke your agent/proxy's power under your durable power of attorney for health care at any time by executing a new durable power of attorney for health care or by otherwise specifying in writing that you wish to revoke it.

What other important facts should I know?

A pregnant patient's Arkansas Declaration will not be honored if it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

Instructions for Completing Your Arkansas Organ Donation Form

How do I make my Arkansas Organ Donation Form legal?

The law requires that you sign your Organ Donation Form in the presence of two witnesses. Both witnesses must be 18 years of age or older. At least one of the witnesses must be a disinterested party (i.e. not a family member nor potential recipient of your donation).

Who may receive my anatomical gift?

Under Arkansas law, you may make a gift of all or part of your body for transplantation, therapy, research, or education to any of the following entities: a tissue or eye bank or any other organ procurement organization; hospital; accredited medical school, dental school, college, or university; or any individual designated as the recipient by you.

Can others make a gift for me?

Unless you explicitly prohibit such gifts, your agent/proxy or a family member has the authority to make anatomical gifts on your behalf.

Can I refuse to make a gift?

You can refuse to make a gift in any of these other ways: (1) any writing — including your Organ Donation Form — signed by you refusing to make such donations; (2) in your will; or (3) during a terminal illness or injury, you communicate such refusal to at least two adults, at least one of whom is a disinterested witness.

How can I revoke my gift?

You can revoke or amend an anatomical gift by: (1) any writing signed by you revoking or amending such gift that is witnessed by at least two adults, at least one of whom is a disinterested witness; (2) by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift. If the gift was not made in a will, you may revoke or amend it by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 1 OF 4

INITIAL THE OPTION THAT REFLECTS YOUR WISHES (CHOOSE ONLY ONE OPTION)

IF YOU CHOOSE OPTION 2, PRINT THE NAME OF YOUR AGENT/PROXY— THIS SHOULD BE THE SAME AGENT/PROXY THAT YOU IDENTIFY ON P. 2

INITIAL THE OPTION(S) THAT REFLECT YOUR WISHES

ADD PERSONAL INSTRUCTIONS (IF ANY)

Declaration

If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to (initial only one)

_____ 1. Withhold or withdraw treatments that only prolong the process of dying and are not necessary to my comfort or to alleviate pain.

_____ 2. Follow the instructions of _____, whom I appoint as my health care agent/proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

In addition, the following specific directives apply (initial the option(s) that apply):

_____ a. It is my specific directive that nutrition may be withheld after consultation with my attending physician.

_____ b. It is my specific directive that hydration may be withheld after consultation with my attending physician.

_____ c. It is my specific directive that nutrition may not be withheld.

_____ d. It is my specific directive that hydration may not be withheld.

Other directions in the event I am terminally ill and cannot make decisions, or I am permanently unconscious:

_____
_____
_____
_____
_____
_____
_____

ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 2 OF 4

PRINT YOUR NAME

I, _____, hereby
(your name)
appoint:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT/PROXY

_____
(name, home address and telephone number of agent/proxy)

_____

as my health care agent/proxy to make any and all health care decisions for me, except to the extent that I state otherwise.

This Durable Power of Attorney for Health Care shall take effect in the event of my disability or incapacity, such that I become unable to make my own health care decisions. My health care agent/proxy and any alternate health care agent/proxy as appointed below shall have the authority to make all health care decisions regarding any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental health or personal care.

If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, my health care agent/proxy and any alternate health care agent/proxy shall also have the authority to make decisions regarding the providing, withholding, or withdrawing of life sustaining treatment as my Proxy pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

If the health care agent/proxy I appoint is unable, unwilling or unavailable to act as my health care agent/proxy, then I appoint:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT/PROXY

_____
(name, home address and telephone number of alternate agent/proxy)

_____

as my alternate health care agent/proxy to make any and all health care decisions for me, except to the extent that I state otherwise.

ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 3 OF 4

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Other Directions, in the event of my disability or incapacitation, such that I become unable to make my own health care decisions:

ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 4 OF 4

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

Signed this _____ day of _____, _____.
(day) (month) (year)

Signature_____

Address _____

_____

WITNESSING PROCEDURE

Statement by Witnesses (must be 18 or older):
I declare that the person who signed above appeared to execute this declaration and durable power of attorney for health care willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness _____
(Signature) (Date)

_____
(Print name)

YOUR WITNESSES MUST SIGN AND PRINT THEIR NAMES AND ADDRESSES

Address _____

_____

Witness _____
(Signature) (Date)

_____
(Print name)

Address _____

_____

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

ARKANSAS ORGAN DONATION FORM - PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Arkansas law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Arkansas law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____ _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your *Arkansas Declaration and Durable Power of Attorney for Health Care* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent/proxy and alternate agent/proxy, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent/proxy(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Arkansas document.

7. Be aware that your Arkansas document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining this form. **Caring Connections does not distribute these forms.**

GEORGIA
Advance Directive
Planning for Important Health Care Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you could receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

This packet contains the **Georgia Advance Directive for Health Care**, which protects your right to refuse medical treatment that you do not want or to request treatment you do want, in the event you lose the ability to make decisions yourself. The form contains three parts, any number of which may be filled out, and a fourth signature page that must be filled out for any of the three other parts to be effective.

Part One: **Health Care Agent**. This allows you to choose someone to make health care decisions for you if you cannot (or do not want to) make health care decisions for yourself. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body.

Your health care agent's power becomes effective when your doctor determines that you are no longer able to make or communicate your health care decisions or when you decide to have your health care agent make decisions for you.

Part Two: **Treatment Preferences**. This part allows you to state your treatment preferences if you are (1) unable to communicate your treatment preferences, and (2) your physician and one other physician determine that you either have a terminal condition or are in a state of permanent unconsciousness. If you also have a health care agent, then your agent is authorized to make all decisions discussed in Part Two, but will be guided by your written Treatment Preferences as well as any other factors you may have listed in section 4 of Part One.

Part Three: **Guardianship**. This part allows you to nominate a person to be your guardian should one ever be needed.

Part Four: **Signatures**. This part needs to be filled out in order to make any of the three other parts effective. All three preceding parts are optional. You are free to fill out any or all of them.

These forms do not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney for mental health care.

Note: These documents will be legally binding only if the person completing them is a competent adult, at least 18 years old, or an emancipated youth.

COMPLETING YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

How do I make my Advance Directive for Health Care legal?

The law requires that you sign your document, or another person signs it in your presence and at your express direction, in the presence of two witnesses who must be at least 18 years of age and of sound mind.

Your witnesses cannot be your health care agent, someone who will knowingly inherit anything from you or otherwise gain a financial benefit from your death, or someone who is directly involved in your health care.

Only one witness can be an employee, agent, or medical staff member of the facility in which you are receiving health care.

Note: You do not need to notarize your Georgia Advance Directive for Health Care.

Whom should I appoint as my agent?

Your health care agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your health care agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your health care agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

No physician or health care provider may act as your health care agent if he or she is directly involved in your health care.

You can appoint a second and third person as your alternate health care agent(s). The alternate(s) will step in if the first person you name as agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my Advance Directive for Health Care?

One of the strongest reasons for naming a health care agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your health care agent carry out your wishes, but be careful that you do not unintentionally restrict your health care agent's power to act in your best interest. In any event, be sure to talk with your health care agent about your future medical care and describe what you consider to be an acceptable "quality of life."

COMPLETING YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE (CONTINUED)

What if I change my mind?

Revocation

You may revoke your Georgia advance directive for health care at any time, regardless of your mental or physical condition, by:

- obliterating, burning, tearing, or otherwise destroying your document,
- signing and dating a written revocation or directing another person to do so (if you are receiving health care in a health care facility, the revocation must be communicated to your attending physician) , or
- orally revoking your document in the presence of a witness, at least 18 years of age, who must sign and date a written confirmation of your revocation within 30 days (if you are receiving health care in a health care facility, the revocation must be communicated to your attending physician).
- by completing a new advance directive for health care. A new advance directive will revoke an older advance directive to the extent that they are inconsistent with each other.

Change in Marital Status

If you get married after completing your advance directive for health care and you have not named your spouse as your health care agent, your marriage automatically revokes the power of your health care agent. If you have appointed your spouse as your health care agent and you divorce or the marriage is annulled, your health care agent's power is automatically revoked. You can, however, specify that you do not want these changes to occur in section 8 in PART TWO of your advance directive for health care.

What other important facts should I know?

Pregnancy

If you are a woman and would like your treatment preferences regarding withholding or withdrawal of life-sustaining procedures, nourishment, or hydration to be honored even if you are pregnant, you must initial the statement in section 9 in PART TWO of the advance directive for health care form.

State law requires that, before honoring a pregnant patient's Treatment Preferences, the attending physician must first determine whether the fetus is viable. If the fetus is viable, your treatment preferences will not be honored, even if you initial section 9.

Guardianship

Part III of your advance directive for health care provides space where you can nominate someone to serve as your guardian if there should come a time when you need a court-appointed guardian. Unless a court specifies otherwise, your guardian has no power to make any personal or health care decisions granted to your agent under your advance directive for health care.

INSTRUCTIONS

PRINT YOUR NAME AND BIRTH DATE

INTRODUCTION

GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE - PAGE 1 OF 12

By: _____
(Print Name)
Date of Birth: _____
(Month/Day/Year)

This advance directive for health care has four parts:

PART ONE: HEALTH CARE AGENT. This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

PART TWO: TREATMENT PREFERENCES. This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

PART THREE: GUARDIANSHIP. This part allows you to nominate a person to be your guardian should one ever be needed.

PART FOUR: EFFECTIVENESS AND SIGNATURES. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

INSTRUCTIONS

PRINT YOUR NAME AND BIRTH DATE

INTRODUCTION

GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE - PAGE 1 OF 12

By: _____
(Print Name)
Date of Birth: _____
(Month/Day/Year)

This advance directive for health care has four parts:

PART ONE: HEALTH CARE AGENT. This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

PART TWO: TREATMENT PREFERENCES. This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

PART THREE: GUARDIANSHIP. This part allows you to nominate a person to be your guardian should one ever be needed.

PART FOUR: EFFECTIVENESS AND SIGNATURES. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

INSTRUCTIONS

PART ONE: HEALTH CARE AGENT

[PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. Unless you specify otherwise in section 8 of PART TWO, if you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. Unless you specify otherwise in section 8 of PART TWO, if you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.]

PRINT THE NAME AND ADDRESS OF YOUR HEALTH CARE AGENT

(1) HEALTH CARE AGENT

I select the following person as my health care agent to make health care decisions for me:

Name: _____

Address: _____

_____

Telephone Numbers: _____

(Home, Work, and Mobile)

(2) BACK-UP HEALTH CARE AGENT

*[**This section is optional.** PART ONE will be effective even if this section is left blank.]*

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

PRINT NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF YOUR ALTERNATE HEALTH CARE AGENTS

Name: _____

Address: _____

_____

Telephone Numbers: _____

(Home, Work, and Mobile)

Name: _____

Address: _____

_____

Telephone Numbers: _____

(Home, Work, and Mobile)

INSTRUCTIONS

DESCRIPTION OF POWERS OF HEALTH CARE AGENT

(3) GENERAL POWERS OF HEALTH CARE AGENT

My health care agent will make health care decisions for me when I am unable to make my health care decisions or I choose to have my health care agent make my health care decisions. My health care agent will have the same authority to make any health care decision that I could make.

My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that, under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

(4) GUIDANCE FOR HEALTH CARE AGENT

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

INSTRUCTIONS

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) AUTOPSY
My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

INITIAL IF YOU DO NOT WANT YOUR HEALTH CARE AGENT TO HAVE POWER TO AUTHORIZE AN AUTOPSY

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY
My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

INITIAL STATEMENTS THAT YOU WANT TO APPLY, IF ANY

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY
My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

INITIAL HERE IF YOU WANT SOMEONE OTHER THAN YOUR HEALTH CARE AGENT TO MAKE FINAL DISPOSITION DECISIONS

_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(Home, Work, and Mobile)

INITIAL THE ONE STATEMENT THAT REFLECTS YOUR WISH

I wish for my body to be:
_____ (Initials) Buried

OR
_____ (Initials) Cremated

INSTRUCTIONS

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

INITIAL IF YOU DO NOT WANT YOUR HEALTH CARE AGENT TO HAVE POWER TO AUTHORIZE AN AUTOPSY

(A) AUTOPSY
My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY
My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

INITIAL STATEMENTS THAT YOU WANT TO APPLY, IF ANY

[Initial each statement that you want to apply.]

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

INITIAL HERE IF YOU WANT SOMEONE OTHER THAN YOUR HEALTH CARE AGENT TO MAKE FINAL DISPOSITION DECISIONS

(C) FINAL DISPOSITION OF BODY
My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(Home, Work, and Mobile)

INITIAL THE ONE STATEMENT THAT REFLECTS YOUR WISH

I wish for my body to be:
_____ (Initials) Buried

OR
_____ (Initials) Cremated

INSTRUCTIONS

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

INITIAL IF YOU DO NOT WANT YOUR HEALTH CARE AGENT TO HAVE POWER TO AUTHORIZE AN AUTOPSY

(A) AUTOPSY
My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY
My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

INITIAL STATEMENTS THAT YOU WANT TO APPLY, IF ANY

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY
My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

INITIAL HERE IF YOU WANT SOMEONE OTHER THAN YOUR HEALTH CARE AGENT TO MAKE FINAL DISPOSITION DECISIONS

_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(Home, Work, and Mobile)

INITIAL THE ONE STATEMENT THAT REFLECTS YOUR WISH

I wish for my body to be:
_____ (Initials) Buried

OR
_____ (Initials) Cremated

INSTRUCTIONS

INITIAL THE STATEMENTS THAT REFLECT YOUR WISH

YOU MAY INITIAL BOTH STATEMENTS

PART TWO: TREATMENT PREFERENCES

[PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.]

(6) CONDITIONS

PART TWO will be effective if I am in any of the following conditions:

[Initial each condition in which you want PART TWO to be effective.]

_____ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____ (Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be certified in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

INSTRUCTIONS

(7) TREATMENT PREFERENCES

[State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, regardless of which choice you make, but you may also want to state your specific preferences regarding pain relief in the next section.]

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

INITIAL ONE STATEMENT THAT REFLECTS YOUR WISH

INITIAL ONLY ONE (A, B, OR C)

(A) _____ (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _____ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) _____ (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:
[Initial each statement that you want to apply to option (C).]

IF YOU INITIAL (C), INITIAL EACH STATEMENT THAT YOU WANT TO APPLY

_____ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_____ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_____ (Initials) If I need assistance to breathe, I want to have a ventilator used.

_____ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

INSTRUCTIONS

OPTIONAL SECTION

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(8) ADDITIONAL STATEMENTS

[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]

INSTRUCTIONS

INITIAL HERE IF YOU WANT PART TWO TO BE CARRIED OUT IF YOU ARE PREGNANT AND YOUR FETUS IS NOT VIABLE

(9) IN CASE OF PREGNANCY

[PART TWO will be effective even if this section is left blank.]

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) I want PART TWO to be carried out if my fetus is not viable.

INSTRUCTIONS

INITIAL YOUR PREFERENCE REGARDING NOMINATION OF YOUR GUARDIAN, IN THE EVENT YOU NEED TO HAVE ONE APPOINTED BY A COURT

PART THREE: GUARDIANSHIP

(10) GUARDIANSHIP

*[**PART THREE is optional.** This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.]*

[State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]

(A) _____ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) _____ (Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

INSTRUCTIONS

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.
This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

INITIAL HERE IF YOU WANT TO LIMIT WHEN THIS ADVANCE DIRECTIVE IS EFFECTIVE

_____ (Initials) This advance directive for health care will become effective

on or upon _____

and will terminate on or upon _____.

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses.

Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.
A witness cannot be:

- *A person who was selected to be your health care agent or back-up health care agent in PART ONE;*
- *A person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or*
- *A person who is directly involved in your health care.*

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]

SIGN AND DATE

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____ _____
(Signature of Declarant) (Date)

INSTRUCTIONS

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR ADDRESSES HERE

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_____ _____
(Signature of witness) (Date)

Print Name: _____

Address: _____

_____ _____
(Signature of witness) (Date)

Print Name: _____

Address: _____

_____

[This form does not need to be notarized.]

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your *Georgia Advance Directive for Health Care* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Georgia document.

7. Be aware that your Georgia document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**

MISSISSIPPI
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health-care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health-care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR MISSISSIPPI ADVANCE HEALTH-CARE DIRECTIVE

This packet contains a legal document, a **Mississippi Advance Health-Care Directive,** that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete any or all of the first four parts, depending on your advance planning needs. You must complete part 5.

Part 1 is a **Power of Attorney for Health Care**. This part lets you name someone (an agent) to make decisions about your health care in the event that you can no longer speak for yourself. The power of attorney for health care becomes effective when your doctor determines that you can no longer make or communicate your health-care decisions, unless you elect for it to be effective immediately.

Part 2 includes your **Individual Instructions**. This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself and

- are terminally ill,
- are permanently unconscious, or
- the likely risks and burdens of the proposed treatment would outweigh the expected benefits.

Your individual instructions go into effect when your physician determines that you can no longer communicate your wishes and one of the conditions listed above exists.

Part 3 allows you to express your wishes regarding organ donation.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Part 5 contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult who is 18 years of age or older or an emancipated minor.

Instructions for Completing Your Mississippi Advance Health-Care Directive

How do I make my Advance Health-Care Directive legal?

In order to make your Advance Health-Care Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses. Your witnesses must be at least 18 years of age. Neither of your witnesses can be:
    - the person you appointed as your agent,
    - a health-care provider, or
    - an employee of a health-care provider or facility.

In addition, one of your witnesses **cannot** be:

- related to you by blood or marriage or adoption,
- entitled to any part of your estate either under your last will and testament or by operation of law.

OR

2. Sign your document in the presence of a notary public.

Who should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health-care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Unless related by blood, marriage, or adoption, your agent cannot be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Should I add personal instructions to my Advance Health-Care Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health-care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

To revoke the designation of an agent in Part 1 of your Mississippi Advance Health-Care Directive, you must do so in a signed writing or by personally informing your primary physician or the provider who has undertaken primary responsibility for your healthcare.

Unless you provide otherwise, a decree of annulment, divorce, dissolution of marriage, or legal separation automatically revokes a previous designation of your spouse as your agent.

You make revoke all or part of your advance health-care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke by, for example, destroying the advance health-care directive.

A later advance directive that conflicts with an earlier advance directive will revoke the earlier advance directive to the extent of the conflict.

EXPLANATION

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;

(b) Select or discharge health-care providers and institutions;

(c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

EXPLANATION CONTINUED

Part 4 of this form lets you authorize your agent to make an anatomical gift on your behalf in accordance with your wishes if you have not done so yourself.

After completing this form, sign and date the form at the end in **Part 5** and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this Advance Health-Care Directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) **DESIGNATION OF AGENT**:

PRINT YOUR NAME

I, _____, designate the
(your name)
following individual as my agent to make health-care decisions for me:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

_____
(Name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT

_____
(Name of individual you choose as first alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

_____
(Name of individual you choose as second alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

2) **AGENT'S AUTHORITY**: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

INITIAL THE BOX ONLY IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 3, 4 OR 5 THAT DO NOT REFLECT YOUR WISHES

(4) **AGENT'S OBLIGATION**: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN**: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) **END-OF-LIFE DECISIONS**: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

INITIAL ONLY ONE BOX

[ ] (a) **Choice NOT To Prolong Life**
I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

[ ] (b) **Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

INITIAL THE BOX ONLY IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION REGARDLESS OF YOUR MEDICAL CONDITION

(7) **ARTIFICIAL NUTRITION AND HYDRATION**: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box.
If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT COMFORT TREATMENT

(8) **RELIEF FROM PAIN**: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

_____

(Add additional sheets if needed.)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH-CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(9) **OTHER WISHES**: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

(10) **EFFECT OF COPY**: A copy of this form has the same effect as the original.

PART 3
PRIMARY PHYSICIAN
(OPTIONAL)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN

If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

PART 4
AUTHORIZATION FOR ORGAN DONATION
(OPTIONAL)

CROSS OUT AND INITIAL THIS STATEMENT IF YOU DO NOT AUTHORIZE YOUR AGENT TO MAKE AN ANATOMICAL GIFT OF YOUR ORGANS OR PHYSICAL PARTS

OTHERWISE, INITIAL YOUR ORGAN DONATION WISHES

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR ANATOMICAL GIFT

(12) I authorize my agent to make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

Upon my death, I wish to donate:
_____ My body for anatomical study if needed.
_____ Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes:

_____
_____
_____

I authorize the use of my organs, tissues, or eyes:
_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

This authority granted to my patient advocate to make an anatomical gift is limited as follows *(here list limitations or special wishes, if any):*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

PART 5: EXECUTION

This advance directive will not be valid unless it is EITHER:

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW (P. 15)

(A) Signed in the presence of two adult witnesses, at least 18 years of age, who must also sign the document to show that they personally know you and believe you to be of sound mind and under no duress, fraud, or undue influence.

Neither of your witnesses can be:

- the person you appointed as your agent,
- a health-care provider, or an employee of a health-care provider or facility.

In addition, one of your witnesses cannot be:

- related to you by blood or marriage or adoption,
- entitled to any part of your estate either under your last will and testament or by operation of law.

(If you choose to sign with witnesses, use alternative 1 below).

OR

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW (P. 16)

(B) Witnessed by a notary.

(If you choose to have your signature notarized, use alternative 2, below).

Alternative No. 1: Sign Before Witnesses

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____ _____
(signature) (date)

_____
(printed name)

PRINT YOUR NAME AND ADDRESS

_____
(address)

DECLARATION OF WITNESSES

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

Witness No. 1

WITNESS NO. 1 MUST BE UNRELATED TO YOU AND NOT HAVE ANY INTEREST IN YOUR ESTATE

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this advance directive in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____ _____
(signature of witness) (date)

_____
(printed name of witness)

Witness No. 2

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this advance directive in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

_____ _____
(signature of witness) (date)

_____
(printed name of witness)

Alternative No. 2: Sign Before a Notary Public

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____ _____
(signature) (date)

PRINT YOUR NAME AND ADDRESS

_____
_____
(printed name)

_____
_____
(address)

A NOTARY PUBLIC SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

Notary Public

State of _____

County of _____

On this _____ day of _____, in the year_____,

before me, _____ (insert name of notary public)

appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal

_____
(Signature of Notary Public)

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health-Care Directive, Now What?

1. Your Mississippi Advance Health-Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agents, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health-care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Mississippi document.

7. Be aware that your Mississippi document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**

Surgical Procedures Excluded from Payment in ASCs for 2014

HCPCS Code	Short Description
11004	Debride genitalia & perineum
11005	Debride abdom wall
11006	Debride genit/per/abdom wall
11008	Remove mesh from abd wall
15756	Free myo/skin flap microvasc
15757	Free skin flap microvasc
15758	Free fascial flap microvasc
15999	Removal of pressure sore
16036	Escharotomy addl incision
17999	Skin tissue procedure
19260	Removal of chest wall lesion
19271	Revision of chest wall
19272	Extensive chest wall surgery
19305	Mast radical
19306	Mast rad urban type
19307	Mast mod rad
19361	Breast reconstr w/lat flap
19364	Breast reconstruction
19367	Breast reconstruction
19368	Breast reconstruction
19369	Breast reconstruction
19499	Breast surgery procedure
20100	Explore wound neck
20101	Explore wound chest
20102	Explore wound abdomen
20660	Apply rem fixation device
20661	Application of head brace
20664	Application of halo
20802	Replantation arm complete
20805	Replant forearm complete
20808	Replantation hand complete
20816	Replantation digit complete
20824	Replantation thumb complete
20827	Replantation thumb complete
20838	Replantation foot complete
20936	Sp bone agrft local add-on
20937	Sp bone agrft morsel add-on
20938	Sp bone agrft struct add-on
20955	Fibula bone graft microvasc
20956	Iliac bone graft microvasc
20957	Mt bone graft microvasc
20962	Other bone graft microvasc
20969	Bone/skin graft microvasc
20970	Bone/skin graft iliac crest
20999	Musculoskeletal surgery
21045	Extensive jaw surgery
21049	Excis uppr jaw cyst w/repair
21089	Prepare face/oral prosthesis
21141	Reconstruct midface lefort
21142	Reconstruct midface lefort
21143	Reconstruct midface lefort
21145	Reconstruct midface lefort
21146	Reconstruct midface lefort

HCPCS Code	Short Description
21147	Reconstruct midface lefort
21151	Reconstruct midface lefort
21154	Reconstruct midface lefort
21155	Reconstruct midface lefort
21159	Reconstruct midface lefort
21160	Reconstruct midface lefort
21172	Reconstruct orbit/forehead
21175	Reconstruct orbit/forehead
21179	Reconstruct entire forehead
21180	Reconstruct entire forehead
21182	Reconstruct cranial bone
21183	Reconstruct cranial bone
21184	Reconstruct cranial bone
21188	Reconstruction of midface
21193	Reconst lwr jaw w/o graft
21194	Reconst lwr jaw w/graft
21195	Reconst lwr jaw w/o fixation
21196	Reconst lwr jaw w/fixation
21247	Reconstruct lower jaw bone
21255	Reconstruct lower jaw bone
21256	Reconstruction of orbit
21261	Revise eye sockets
21263	Revise eye sockets
21268	Revise eye sockets
21299	Cranio/maxillofacial surgery
21343	Treatment of sinus fracture
21344	Treatment of sinus fracture
21346	Treat nose/jaw fracture
21347	Treat nose/jaw fracture
21348	Treat nose/jaw fracture
21365	Treat cheek bone fracture
21366	Treat cheek bone fracture
21385	Treat eye socket fracture
21386	Treat eye socket fracture
21387	Treat eye socket fracture
21395	Treat eye socket fracture
21408	Treat eye socket fracture
21422	Treat mouth roof fracture
21423	Treat mouth roof fracture
21431	Treat craniofacial fracture
21432	Treat craniofacial fracture
21433	Treat craniofacial fracture
21435	Treat craniofacial fracture
21436	Treat craniofacial fracture
21470	Treat lower jaw fracture
21499	Head surgery procedure
21510	Drainage of bone lesion
21615	Removal of rib
21616	Removal of rib and nerves
21620	Partial removal of sternum
21627	Sternal debridement
21630	Extensive sternum surgery
21632	Extensive sternum surgery
21705	Revision of neck muscle/rib
21740	Reconstruction of sternum
21742	Repair stern/nuss w/o scope
21743	Repair sternum/nuss w/scope
21750	Repair of sternum separation
21810	Treatment of rib fracture(s)
21825	Treat sternum fracture

HCPCS Code	Short Description
21899	Neck/chest surgery procedure
22010	I&d p-spine c/t/cerv-thor
22015	I&d p-spine l/s/ls
22100	Remove part of neck vertebra
22101	Remove part thorax vertebra
22110	Remove part of neck vertebra
22112	Remove part thorax vertebra
22114	Remove part lumbar vertebra
22116	Remove extra spine segment
22206	Cut spine 3 col thor
22207	Cut spine 3 col lumb
22208	Cut spine 3 col addl seg
22210	Revision of neck spine
22212	Revision of thorax spine
22214	Revision of lumbar spine
22216	Revise extra spine segment
22220	Revision of neck spine
22222	Revision of thorax spine
22224	Revision of lumbar spine
22226	Revise extra spine segment
22318	Treat odontoid fx w/o graft
22319	Treat odontoid fx w/graft
22325	Treat spine fracture
22326	Treat neck spine fracture
22327	Treat thorax spine fracture
22328	Treat each add spine fx
22532	Lat thorax spine fusion
22533	Lat lumbar spine fusion
22534	Lat thor/lumb addl seg
22548	Neck spine fusion
22551	Neck spine fuse&remov bel c2
22552	Addl neck spine fusion
22554	Neck spine fusion
22556	Thorax spine fusion
22558	Lumbar spine fusion
22585	Additional spinal fusion
22586	Prescrl fuse w/ instr l5/s1
22590	Spine & skull spinal fusion
22595	Neck spinal fusion
22600	Neck spine fusion
22610	Thorax spine fusion
22612	Lumbar spine fusion
22614	Spine fusion extra segment
22630	Lumbar spine fusion
22632	Spine fusion extra segment
22633	Lumbar spine fusion combined
22634	Spine fusion extra segment
22800	Fusion of spine
22802	Fusion of spine
22804	Fusion of spine
22808	Fusion of spine
22810	Fusion of spine
22812	Fusion of spine
22818	Kyphectomy 1-2 segments
22819	Kyphectomy 3 or more
22830	Exploration of spinal fusion
22840	Insert spine fixation device
22841	Insert spine fixation device
22842	Insert spine fixation device
22843	Insert spine fixation device

HCPCS Code	Short Description
22844	Insert spine fixation device
22845	Insert spine fixation device
22846	Insert spine fixation device
22847	Insert spine fixation device
22848	Insert pelv fixation device
22849	Reinsert spinal fixation
22850	Remove spine fixation device
22851	Apply spine prosth device
22852	Remove spine fixation device
22855	Remove spine fixation device
22856	Cerv artific diskectomy
22857	Lumbar artif diskectomy
22861	Revise cerv artific disc
22862	Revise lumbar artif disc
22864	Remove cerv artif disc
22865	Remove lumb artif disc
22899	Spine surgery procedure
22999	Abdomen surgery procedure
23200	Resect clavicle tumor
23210	Resect scapula tumor
23220	Resect prox humerus tumor
23335	Shoulder prosthesis removal
23470	Reconstruct shoulder joint
23472	Reconstruct shoulder joint
23473	Revis reconst shoulder joint
23474	Revis reconst shoulder joint
23900	Amputation of arm & girdle
23920	Amputation at shoulder joint
23929	Shoulder surgery procedure
24150	Resect distal humerus tumor
24900	Amputation of upper arm
24920	Amputation of upper arm
24930	Amputation follow-up surgery
24931	Amputate upper arm & implant
24935	Revision of amputation
24940	Revision of upper arm
24999	Upper arm/elbow surgery
25170	Resect radius/ulnar tumor
25900	Amputation of forearm
25905	Amputation of forearm
25909	Amputation follow-up surgery
25915	Amputation of forearm
25920	Amputate hand at wrist
25924	Amputation follow-up surgery
25927	Amputation of hand
25999	Forearm or wrist surgery
26551	Great toe-hand transfer
26553	Single transfer toe-hand
26554	Double transfer toe-hand
26556	Toe joint transfer
26989	Hand/finger surgery
26992	Drainage of bone lesion
27005	Incision of hip tendon
27006	Incision of hip tendons
27025	Incision of hip/thigh fascia
27027	Buttock fasciotomy
27030	Drainage of hip joint
27036	Excision of hip joint/muscle
27054	Removal of hip joint lining
27057	Buttock fasciotomy w/dbrdmt

HCPCS Code	Short Description
27070	Part remove hip bone super
27071	Part removal hip bone deep
27075	Resect hip tumor
27076	Resect hip tum incl acetabul
27077	Resect hip tum w/innom bone
27078	Rsect hip tum incl femur
27090	Removal of hip prosthesis
27091	Removal of hip prosthesis
27120	Reconstruction of hip socket
27122	Reconstruction of hip socket
27125	Partial hip replacement
27130	Total hip arthroplasty
27132	Total hip arthroplasty
27134	Revise hip joint replacement
27137	Revise hip joint replacement
27138	Revise hip joint replacement
27140	Transplant femur ridge
27146	Incision of hip bone
27147	Revision of hip bone
27151	Incision of hip bones
27156	Revision of hip bones
27158	Revision of pelvis
27161	Incision of neck of femur
27165	Incision/fixation of femur
27170	Repair/graft femur head/neck
27175	Treat slipped epiphysis
27176	Treat slipped epiphysis
27177	Treat slipped epiphysis
27178	Treat slipped epiphysis
27179	Revise head/neck of femur
27181	Treat slipped epiphysis
27185	Revision of femur epiphysis
27187	Reinforce hip bones
27222	Treat hip socket fracture
27226	Treat hip wall fracture
27227	Treat hip fracture(s)
27228	Treat hip fracture(s)
27232	Treat thigh fracture
27235	Treat thigh fracture
27236	Treat thigh fracture
27240	Treat thigh fracture
27244	Treat thigh fracture
27245	Treat thigh fracture
27248	Treat thigh fracture
27253	Treat hip dislocation
27254	Treat hip dislocation

Cigna- HealthSpring has adopted evidence based clinical practice guidelines as roadmaps for healthcare decision-making targeting specific clinical circumstances. Cigna-HealthSpring promotes the use of clinical practice guidelines to:

- ✓ Define clear goals of care based on the best available scientific evidence
- ✓ Reduce variation in care and outcomes
- ✓ Provide a more rational basis for clinical management of some conditions
- ✓ Comply with accreditation standards and regulatory expectations

The table below contains the clinical practice guidelines approved by Cigna-HealthSpring's Clinical Guidelines Steering Committee. The table also contains links to the websites with the most current version of the guideline.

Topic	*Name of Guideline*	*Organization / Web Address*
Acute Stress Disorder or Post Traumatic Stress Disorder	APA Practice Guideline for the Treatment of Patients with Acute Stress Disorder or Post Traumatic Stress Disorder, Second Edition(2004) APA Practice Guideline Watch for the for the Practice Guideline for the Treatment of Patients with Patients with Acute Stress Disorder or Post Traumatic Stress Disorder, 2009	American Psychiatric Association http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1670530 http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1682793
Antithrombotic Therapy and Prevention of Thrombosis	Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines	American College of Chest Physicians http://journal.publications.chestnet.org/article.aspx?articleID=1159399
Bipolar Disorder	APA Practice Guideline for the Treatment of Patients with Bipolar Disorder, Second Edition (2002) APA Practice Guideline Watch for the for the Practice Guideline for the Treatment of Patients with Bipolar Disorder, (2009)	American Psychiatric Association http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1669577 http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1682557
Cholesterol Management in Adults	ICSI Health Care Guideline: Lipid Management in Adults; Eleventh Edition	Agency for Healthcare Research and Quality http://www.guideline.gov/content.aspx?id=36062&search=lipid+management#top
Chronic Heart Failure in Adults	2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults Primary Care Management of Chronic Stable Angina and Asymptomatic Suspected or Known Coronary Artery Disease: Ann Intern Med. 5 October 2004;141(7):562-567	American College of Cardiology http://circ.ahajournals.org/content/119/14/e391.full.pdf American College of Physicians http://annals.org/article.aspx?volume=141&issue=7&page=562
Chronic Obstructive Pulmonary Disease in Adults	Chronic Obstructive Pulmonary Disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care	Agency for Healthcare Research and Quality http://www.guideline.gov/content.aspx?id=23801&search=copd
Community-acquired Pneumonia in Adults	Infectious Diseases Society of America/American Thoracic Society consensus guidelines on the management of community-acquired pneumonia in adults	Infectious Diseases Society of America/American Thoracic Society http://cid.oxfordjournals.org/content/44/Supplement_2/S27.full.pdf+html
Depression	Treatment of Patients With Major Depressive Disorder, Third Edition, May 2010	American Psychiatric Association http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1667485

Topic	*Name of Guideline*	*Organization / Web Address*
Diabetes	Standards of medical care in diabetes. Diabetes Care, Volume 35, Supplement 1, January 2012	American Diabetes Association (ADA) http://care.diabetesjournals.org/content/35/Supplement_1/S11.full.pdf+html
Fall Prevention	Prevention of Falls in Community-Dwelling Older Adults Recommendation Statement May 2012	US Preventative Services Task Force http://www.uspreventiveservicestaskforce.org/uspstf/uspsfalls.htm
Hypertension	2003 The Seventh Report on the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure 2011 Expert Consensus on Hypertension in the Elderly: Executive Summary	National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf http://www.nhlbi.nih.gov/guidelines/hypertension/phycard.pdf Journal of the American College of Cardiology http://www.medpagetoday.com/upload/2011/4/25/j.jacc.2011.01.008v1.pdf
Osteoporosis	Medical Guidelines for Clinical Practice for the Diagnosis and Treatment of Postmenopausal Osteoporosis, 2010	American Association of Clinical Endocrinologists https://www.aace.com/files/osteo-guidelines-2010.pdf
Schizophrenia	Practice Guideline for the Treatment of Patients With Schizophrenia, Second Edition Guideline Watch (September 2009): Practice Guideline for the Treatment of Patients with Schizophrenia	American Psychiatric Association http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1665359 http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1682213
Preventive Services Guideline	Guide to Clinical Preventive Services – 2012 Preventive Services Task Force (USPSTF)	Agency for Healthcare Research and Quality http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html http://www.cdc.gov/vaccines/schedules/downloads/adult/mmwr-adult-schedule.pdf http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

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For more information call toll-free:
1-800-331-6293 (TTY 711),
7 days a week, 8 a.m. - 8 p.m.