For your convenience, some of the more frequently referenced policies and regulatory guidelines have been summarized in this Regulatory Highlights Guide. The guide highlights key regulatory topics that you should be aware of, as well as useful information to help you better serve Cigna-HealthSpring Members. The guide is not intended to be a complete statement of policies and procedures, or all laws and regulations that apply to providers. It is a supporting document to the Provider Manual and you must comply with such provisions set forth in your participating provider agreement.
Cigna-HealthSpring cultivates strong business relationships with Members, providers, HHSC and local community organizations, with the goal of delivering excellent service to each. Our promise to providers is to bring value to their businesses by offering expeditious claims processing and simple administrative requirements. For Members, we strive to:

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

For additional information on the regulatory topics outlined in this guide, please review the current provider manual.

**STAR+PLUS Website:**
starplus.cignahealthspring.com

**TX MMP Website:**
Cigna.com/medicare/healthcare-professionals/tx-mmp
MEMBER INFORMATION

Rights and responsibilities
The Member Information section of the Provider Manual provides useful information to help you better service our Members. In this section, you will find detailed information on the topics below:

MEMBER RIGHTS AND RESPONSIBILITIES

Cigna HealthSpring Members have certain rights and responsibilities that Cigna-HealthSpring and providers must follow (See “Member Rights and Responsibilities” subsection of the S+P and MMP provider manuals). 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 at 1-877-653-0327. Members in MMP can get free help and information from their State Health Insurance Assistance Program (SHIP). Members in STAR+PLUS can get free help and information from the U.S. Department of Health and Human Services (HHS).

PROVIDER ADVICE TO PATIENTS

Cigna-HealthSpring does not prohibit providers, acting within the scope of their practice, from advising, acting, or advocating on behalf of Members about their conditions, risks, and treatment options. Cigna-HealthSpring is committed to promoting dignity, quality of life and quality care for our Members. Cigna-HealthSpring believes that Members and their families deserve the best and that they can have improved quality of life if given the opportunity to understand and access their rights.

ELIGIBILITY VERIFICATION

All Participating Providers are responsible for verifying a Member’s eligibility at each and every visit. Please note that Member data is subject to change. The Centers for Medicare and Medicaid Services (CMS) retroactively terminates MMP Members for various reasons. The Department of Health and Human Services (HHS) retroactively terminates or re-enroll STAR+PLUS Members for various reasons. When this occurs, Cigna-HealthSpring’s claim recovery unit will request a refund from the provider. The provider must then contact CMS Eligibility or HHS to determine the Member’s actual benefit coverage for the date of service in question. Providers may appeal the recovered claim based on the finding from HHS. See section Claims for appeals information.

(continued on next page)
You can verify Member eligibility the following ways:

› Call Cigna-HealthSpring Provider Services at 1-877-653-0331 to verify eligibility for a MMP or STAR+PLUS Member when they cannot present identification or does not appear on your monthly eligibility list.

› Use HSConnect. The Cigna-HealthSpring web portal, HSConnect, allows our providers to verify Member eligibility online by visiting https://starplus.hsconnectonline.com.

› Ask to see the Member’s Identification Card. Each Member is provided with an individual Member identification card. Noted on the ID card is the Member’s identification number, plan code, name of PCP (except STAR+PLUS dual Members), and effective date (except STAR+PLUS dual Members). Since changes do occur with eligibility, the card alone does not guarantee the Member is eligible.

› Use TexMedConnect on the TMHP website at www.tmhp.com.

› Call the Your Texas Benefits provider helpline at 1-855-827-3747.
Each Member is provided with an individual Member identification card. Noted on the MMP ID card is the Member’s identification number, plan code, name of PCP, effective date and MMP logo. The back of the card will list contact numbers for Cigna-HealthSpring’s Member Services, Behavioral Health, Claims, Pharmacy and Authorizations.

Each Member is provided with an individual Member identification card. Noted on the STAR+PLUS ID card is the Member’s identification number, plan code, name of PCP (except STAR+PLUS dual Members), effective date (except STAR+PLUS dual Members) and STAR+PLUS logo. The back of the card will list contact numbers for Cigna-HealthSpring’s Member Services, Behavioral Health, Claims, Pharmacy and Authorizations.
**COVERED 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 Physician a list of their active Members in HSConnect. 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 “Verifying Eligibility” sub-section of the S+P and MMP provider manuals).

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.

**STAR+PLUS DUAL ELIGIBLE INDIVIDUALS:**

Many of your patients may have Medicare as their primary payer and Cigna-HealthSpring STAR+PLUS as their secondary payer for LTSS services. You must coordinate the benefits of these “dual eligible” Cigna-HealthSpring Members by determining whether the Member should be billed for the deductibles, copayments, or coinsurances associated with their benefit plan.
BALANCE BILLING

Providers should not collect payment from or bill a Cigna-HealthSpring Member for any covered services. Do not balance-bill the patient. (See “Balance Billing” sub-section of the S+P and MMP provider manuals).

ADVANCE DIRECTIVES

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

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

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

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
SPECIAL NEEDS PLAN-MODEL OF CARE

Special Needs Plans (SNPs) are designed for specific groups of most vulnerable individuals. The three SNP groups are:

- **D-SNP** – This plan is for dual eligible beneficiaries who are eligible for both Medicaid and Medicare.
- **C-SNP** – Individuals with chronic conditions can enroll in this plan. Cigna-HealthSpring offers a C-SNP for individuals with Diabetes.
- **I-SNP** – This plan is for individuals who are residents of a long-term care facility.

Medicare-Medicaid Plan is required to have a Model of Care (MOC) for each SNP type. The MOC is an evidenced-based care management model which integrates care coordination and benefits for Members enrolled in a Cigna-HealthSpring Special Needs Plans. SNP Members receive additional services and coordination of care to improve their overall health. The Model of Care facilitates the early assessment and identification of health risks through a Health Risk Assessment, the development of an individual care plan, which is monitored by care management teams to identify health status changes. Additional coordination is available by an Interdisciplinary Care Team (ICT). To discuss and/or request a copy of an SNP Member’s care plan, refer an SNP Member for an ICT meeting or participate in an ICT meeting, please contact our Case Management department. Case Management Department phone number will vary by market; visit the “Special Needs Plan-Model of Care” section of the provider manual for contact information. For more information or if you have questions, please contact our Provider Services Department Monday to Friday, 8 a.m. to 5 p.m. Central Standard Time at **877-653-0331**.

CMS mandates annual MOC training. To access the MOC training please select this link: [Cigna.com/medicare/healthcare-professionals/tx-mmp](http://Cigna.com/medicare/healthcare-professionals/tx-mmp)
Cigna-HealthSpring maintains standards for physician participation as set forth in the provider contract and the Provider Manual. Failure to meet any of the participation standards could result to termination/non-renewal of a provider contract.

For detailed information on the rules of participation, visit the following S+P and MMP provider manual sub-sections: Credentialing. Providers can contact Provider Services Department Monday to Friday, 8 a.m. to 5 p.m. Central Standard Time at 877-653-0331 for additional information.
TERMINATION PROCEDURES AND APPEAL RIGHTS

Cigna-HealthSpring provides terminating and non-renewing physicians written notification of the intent to terminate their agreement. Cigna-HealthSpring must make good faith effort to notify all affected Members of termination of Provider thirty (30) calendar days prior to the effective termination of Provider. [42 C.F.R. § 422.111(e).]

CREDENTIALING REQUIREMENTS

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 participation status.

NO ENGAGEMENT ACTIVITIES THAT CONFUSE/MISLEAD

Cigna-HealthSpring will not distribute printed information comparing benefits of different health plans to providers or provider groups unless the materials have received prior approval from CMS and Compliance in accordance with current Medicare marketing guidance. Providers can provide acceptable assistance to patients that are inquiring about Medicare plans. Providers must remain neutral and may not:

- Offer scope of appointment forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge or attempt to persuade Members to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of plan sponsors.
- Offer anything of value to induce plan enrollees to select them as their provider.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Conduct health screenings as a marketing activity.
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distribute materials/applications within an exam room setting.
- Provider and/or provider groups that accept marketing materials from Cigna-HealthSpring must also accept materials from all other MAOs with which they participate.
PLAN NOTIFICATION REQUIREMENTS FOR PROVIDERS

Participating providers must provide written notice to Cigna-HealthSpring no less than 30 days in advance of any changes to their demographic information 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 Operations Representative or Provider Services:

› Practice address.
› Billing address.
› Fax or telephone number.
› Hospital affiliations.
› Practice name.
› Providers joining or leaving the practice (including retirement or death).
› Providers 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 limitation or gender limitations.

Cigna-HealthSpring will also, on a quarterly basis, contact you to verify the demographic information we have on file is accurate. By providing this information and responding in a timely manner, you will ensure that your practice is listed correctly in the Provider Directory.

NOTE: Failure to provide up-to-date and correct demographic information regarding your practice and the physicians that participate may result in the denial of claims for you and your physicians.

PROVIDER ANTI-DISCRIMINATION

No health care professional shall be discriminated against by Cigna-HealthSpring in reimbursement, participation or based on the population of Members served by the health care professional. Any health care provider wishing to contract with Cigna-HealthSpring may submit a Network Interest Profile Form (NIPF) located on our websites. Cigna-HealthSpring reviews all NIPF received and either accept or deny the provider’s request. In no case shall the provider be discriminated against due to the population of Members seen by the provider, but shall be based on a needs assessment performed related to the specialty of the provider. Should a provider be declined participation by Cigna-HealthSpring, a written notice is provided to the provider outlining the reasoning behind the declination.
PROVIDER INFORMATION

Helpful information about your role
The Provider Responsibilities section of the S+P and MMP provider manuals provides helpful information about your role as a Primary Care Provider, Specialist, LTSS or Nursing Facility provider. In addition, you will find detailed information on the topics below.

Providers can contact Provider Services Department Monday to Friday, 8 a.m. to 5 p.m. Central Standard Time at 877-653-0331 for additional information.

**MEDICAL RECORD DOCUMENTATION STANDARDS**

Cigna-HealthSpring has standards for Member medical records. These standards are outlined in the S+P and MMP provider manuals, in the sub-section Medical Record Requirements.

Agreement and the Audit Period. Note: Unless otherwise specifically stated in your provider services agreement, medical records shall be provided in a timely manner to Cigna-HealthSpring and Cigna-HealthSpring Members.

**MAINTENANCE OF MEMBER HEALTH RECORD STANDARDS**

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. For additional information on medical record standards visit the S+P and MMP provider manuals, in the sub-section Medical Record Requirements.
SERVICES PROVIDED WITH CULTURAL COMPETENCE AND LANGUAGE 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.

Participating providers shall provide covered services in a culturally competent manner to all Members by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. Examples of how a provider can meet these requirements include but are not limited to: translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

Cigna-HealthSpring arranges for language interpretation services for over 170 languages through the TeleLanguage. TeleLanguage can be accessed by calling the Cigna-HealthSpring Provider Services Department at 1-877-653-0331. For telephone-interpreting service for the deaf, hard of hearing, deaf-blind, or speech impaired Cigna-HealthSpring can be reached using the State Relay Service (711).

ACCESSIBILITY AND AVAILABILITY REQUIREMENTS

Cigna-HealthSpring ensures that reasonable standards for network accessibility, appointment availability and after-hour call coverage are maintained by contracted providers. Performance standards are published in the Provider Manual and Provider Website on an annual basis, available on demand on the Cigna-HealthSpring provider website and are distributed to providers during initial orientation. In general, providers must ensure that:

- They arrange for Member care 24 hours a day, seven days a week
- They can care for Members during regular business hours as well as for urgent medical events which may occur after normal working hours.
- Members are able to contact providers after normal working hours.

Cigna-HealthSpring measures provider compliance with Access and Availability standards through the appointment availability and after hours care survey. The survey is conducted on a yearly basis for MMP Providers and quarterly basis for STAR+PLUS Providers for randomly selected providers.
QUALITY IMPROVEMENT PROGRAM OVERVIEW

The Quality Improvement program provides guidance for the management and coordination of all quality improvement and quality management activities throughout the Cigna-HealthSpring organization, its affiliates, and delegated entities.

The program describes the processes and resources to continuously monitor, evaluate and improve the clinical care and services provided to enrollees for both their physical and behavioral health. The program also defines the health plan’s methodology for identifying improvement opportunities and for developing and implementing initiatives to impact opportunities identified.

MEDICAL MANAGEMENT / UTILIZATION MANAGEMENT PROGRAM

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

The Utilization Management (UM) process provides an opportunity for Cigna-HealthSpring to:

› Determine the appropriateness of the services;
› Ensure that services are provided at the most appropriate level of care;
› Ensure the services are provided by the most appropriate provider and in the most appropriate setting;
› Ensure that services are covered under the Member’s benefit plan;
› Verify and coordinate other insurance benefits;
› Monitor participating providers’ practice patterns;
› Improve utilization of resources by identifying and correcting patterns of over or under-utilization;
› Identify high-risk Members; and
› Provide utilization data for use in the re-credentialing process.
DISEASE MANAGEMENT

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

The DM program includes the regular assessment of:

› Member needs;
› Member education;
› Health promotion and wellness;
› Review of service utilization;
› Analysis of health outcomes;
› Documentation of interactions and interventions; and
› Clinical and behavioral health rounds.

Interdisciplinary care team meetings where the provider is a valued participant

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

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

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

CLINICAL PRACTICE GUIDELINES

Cigna-HealthSpring’s practice guidelines are based on evidence-based, clinical findings. These practice guidelines are reviewed and updated annually by the Provider Advisory Committee (PAC.) New guidelines are added to meet Member needs and changes in Membership. The clinical practice guidelines, which are available on Cigna-HealthSpring’s S+P and MMP websites.

(visit the Clinical Practice Guidelines section of the S+P and MMP provider manuals)
PHARMACEUTICAL MANAGEMENT

Detailed information regarding Part D drugs and their utilization management (prior authorizations, step therapy, and quantity limits) may be found in the Pharmacy Prescription Benefit section of the provider manual. The most recent plan formularies may be accessed at: [http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/drug-list.html](http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/drug-list.html).

Coverage determinations may be received orally or in writing from the member’s prescribing physicians. For the Provider Call center, please call 1-877-813-5595 or fax 1-866-845-7267.

To ensure timely review of CDs and that the prescriber is aware of CD requirements for the most commonly requested drugs, forms are available online at [http://www.cigna.com/sites/careplantx/member-resources/forms/prior-auth.html](http://www.cigna.com/sites/careplantx/member-resources/forms/prior-auth.html) or by requesting a fax when calling 1-877-813-5595.

If a provider disagrees with the results of a CD, a Part D appeal may be filed within 60 calendar days after the date of the CD decision. Part D appeals may be received orally or in writing from the Member’s prescribing physicians by calling 1-866-845-6962, or faxing 1-866-593-4482.

As part of our ongoing partnership with providers to decrease the unnecessary use and diversion of controlled substances, Cigna-HealthSpring encourages prescribers and pharmacists to fully utilize their state’s prescription drug monitoring program (PDMP). You may find your state’s PDMP at: [https://texas.pmpaware.net](https://texas.pmpaware.net).

PHARMACEUTICAL QUALITY PROGRAMS

Our pharmacy quality programs prospectively and retrospectively engage members and providers in an effort to assure pharmaceuticals are used both safely and judiciously. These initiatives include:

**Narcotic Case Management (NCM):** Pharmacy claims for controlled substances are reviewed monthly for potential overutilization or inappropriate utilization. If our clinical staff determine further investigation is warranted, prescribers will be individually contacted to discuss options for collaborative management.

**Medication Therapy Management (MTM):** Eligible members will be contacted for a comprehensive medication review on an annual basis by our clinical staff. Any potential concerns are forwarded to the prescribing provider along with the member’s six month medication history.

**Drug Utilization Review:** Concurrent drug utilization review occurs at the pharmacy point-of-sale and includes review of a medication’s dosage, interactions, and any duplicate therapies. Retrospective Drug Utilization Review evaluates previous claims data to determine when follow-up with a member or prescriber may be necessary.

(visit the Pharmacy Quality Program section of theMMP Provider Manual)
CLAIM
PAYMENT
Processing, payment, appeal guidelines
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 1-877-653-0331.

TERMS AND CONDITIONS OF PAYMENT

Claims Adjudication, Submission, and Reconsideration guidelines

Timely Filing - As a Cigna-HealthSpring Participating Provider, you have agreed to submit all claims within the timeframes outlined in your provider agreement. Claim Format Standards and required data elements can be found in the S+P and MMP provider manual and must be present for a claim to be considered a clean claim. Cigna-HealthSpring can only pay claims which are submitted accurately. The provider is always responsible for accurate claims submissions. While Cigna-HealthSpring will make its best effort to inform the provider of claims errors, the claim accuracy rests solely with the provider.

PAYMENT AND APPEAL PROCESS

An appeal is a request for Cigna-HealthSpring to review a previously made decision related to medical necessity, clinical guidelines, or prior authorization and referral requirements. You must receive a notice of denial, or remittance advice before you can submit an appeal. Please do not submit your initial claim in the form of an appeal. Appeals can take up to 30 days for review and determination or within the timeframe specified in your contract. Timely filing requirements are not affected or changed by the appeal process or by the appeal outcome. If an appeal decision results in approval of payment contingent upon the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in the Cigna-HealthSpring agreement.

MANUAL/ELECTRONIC BILLING REQUIREMENTS AND ELECTRONIC FUNDS TRANSFER PROCESS

Through our partnership with Change Healthcare, we are pleased to continue offering simpler, more efficient ePayment Solutions such as Electronic Funds Transfer and Electronic Remittance Advice to help you:

- Maximize revenue & profit
- Reduce Costs and errors
- Increase payment efficiency

Additional information on EFT and ERA can be located in the ERA/EFT Enrollment Process section of the provider manual. (For more information on claims processing, payment, appeal guidelines and conditions of payment, please refer to the Billing and Claims Administration section of the S+P and MMP provider manuals.)