

REGULATORY HIGHLIGHTS GUIDE



KEY REGULATORY TOPICS

CUSTOMER INFORMATION	3
PHYSICIAN PARTICIPATION	11
PROVIDER INFORMATION	16
QUALITY IMPROVEMENT PROGRAM	22
CLAIM PAYMENT	31
CORPORATE COMPLIANCE PROGRAM	33

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 customers. 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 is a health services company committed to helping our nation's Medicare and Medicaid beneficiaries live healthier, more active lives through personalized, affordable and easy-to-use health care solutions.

- › We support healthy aging and meet our customers' individual health care needs through personal attention, wellness and preventive care.
- › We take a team approach to health care by supporting the doctor-patient relationship through clinical and customer engagement, holistic care coordination and detailed analytics.
- › We aim for better health results, affordability and customer satisfaction.

For additional information on the regulatory topics outlined in this guide, please review the current Provider Manual at [Cigna.com/medicare/health-care-providers/provider-manual/2019-provider-manual](https://www.cigna.com/medicare/health-care-providers/provider-manual/2019-provider-manual).





CUSTOMER INFORMATION

Rights and responsibilities

The Customer Information section of the Provider Manual provides useful information to help you better service our customers. In this section, you will find detailed information on the topics below:

CUSTOMER RIGHTS AND RESPONSIBILITIES

Cigna-HealthSpring customers have certain rights and responsibilities that Cigna-HealthSpring and providers must follow (See “Customer Rights and Responsibilities” sub-section of the Provider Manual). Cigna-HealthSpring customers have the following rights and responsibilities:

- › The right to be treated with dignity and respect.
- › The right to the privacy of medical records and personal health information.
- › The right to see participating providers, get covered services, and get prescriptions filled within a reasonable period of time.
- › The right to participate with providers in making decisions about their health care.
- › The right to candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- › The right to use advance directives (such as a living will or a power of attorney).
- › The right to voice complaints or appeals about the organization or the care it provides.
- › The right to get information about their health care coverage and cost.
- › The right to get information about Cigna-HealthSpring, its services, plan providers, drug coverage, and costs.
- › The right to take action if they think they have been treated unfairly or their rights are not being respected.
- › The right to make recommendations regarding the organization’s rights and responsibilities policy.
- › A responsibility to supply information (to the extent possible) that Cigna-HealthSpring and its practitioners and providers need in order to provide care.
- › A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- › A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

(continued on next page)

(CUSTOMER RIGHTS AND RESPONSIBILITIES continued)

Customers also have the right to receive more information about their rights and responsibilities. If customers have questions or concerns about their rights and protections, they should be directed to call Customer Service. Customers can also get free help and information from their State Health Insurance Assistance Program (SHIP). Additionally, customers can obtain a free copy of the Customer Medicare Rights and Protections booklet by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. Customers can call 24 hours a day, 7 days a week, or visit [Medicare.gov](https://www.Medicare.gov) to order this booklet or print it directly from their computer.

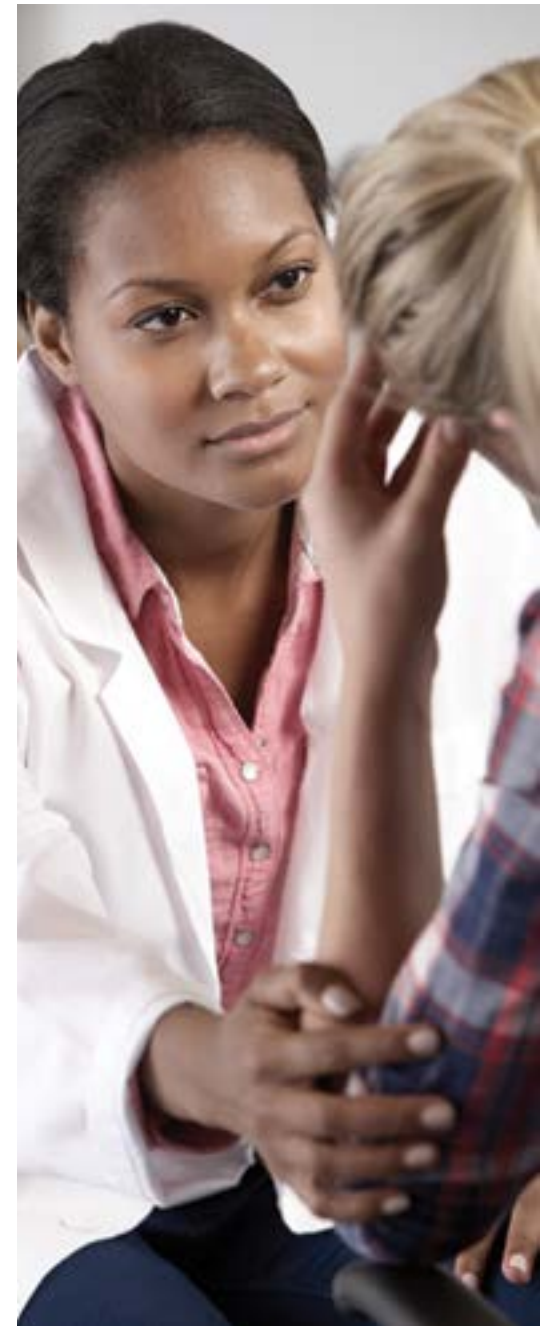
PROVIDER ADVICE TO PATIENTS

Cigna-HealthSpring will not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of an individual who is a patient about:

- › The customer's health status, medical care or treatment options (including alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;
- › The risks, benefits, and consequences of treatment or non-treatment; and
- › The opportunity for the customer to refuse treatment and to express preferences about future treatment decisions.

ELIGIBILITY VERIFICATION

All participating providers are responsible for verifying a customer's eligibility at each and every visit. Please note that customer data is subject to change. The Centers for Medicare & Medicaid Services (CMS) retroactively terminates customers 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 to determine the customer's actual benefit coverage for the date of service in question.



You can verify customer eligibility the following ways:

- › Provider Services: **1-800-230-6138**,
Hours Monday-Friday: 8 a.m. - 5 p.m. CST.
- › Call Cigna-HealthSpring to verify eligibility when the customer cannot present identification or does not appear on your monthly eligibility list.
- › Use HSConnect. The Cigna-HealthSpring web portal allows our providers to verify customer eligibility online by visiting HealthSpring.hsconnectonline.com/HSConnect.
- › Ask to see the customer's Identification Card. Each customer is provided with an individual customer identification card. Noted on the ID card is the customer's identification number, plan code, name of PCP, copayment, and effective date. Since changes do occur with eligibility, the card alone does not guarantee the customer 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 customers with their effective dates. Please be sure to refer to the most current month's Eligibility Report.



CUSTOMER ID CARD EXAMPLE

	
SAMPLE	
<p><Plan Name> ID: <Member ID> Name: <Member Name> PCP: <Provider Name> Phone: <Provider Phone Number> Network: <Network Name> RxBIN: 017010 RxPCN: C HSCARE</p>	
<p>Copays PCP: <copay> Specialist: <copay> ER: <copay> Urgent Care: <copay></p>	

This card does not guarantee coverage or payment.	
<Barcode>	
<p><Services may require a referral by the PCP or authorization by the Health Plan.> <Medicare limiting charges apply></p>	
<p>Customer Service: <phone number> Provider Services: <phone number> Authorization/Referral: <phone number> Medical Claims: <address></p>	<p>TTY: <phone number></p>
<p>Pharmacy Help Desk: <Phone number> Pharmacy Claims: <address></p>	
Website: <URL>	



COVERED SERVICES

All Cigna-HealthSpring customers receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, Cigna-HealthSpring makes available to each participating PCP a list of their active customers. Along with the customer's demographic information, the list includes the name of the plan in which the customer enrolled. Please be aware that recently terminated customers may appear on the list. (See "Eligibility Verification" section of the Provider Manual).

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

DUAL-ELIGIBLE INDIVIDUALS

Many of your patients may have Cigna-HealthSpring as their primary insurance payer and Medicaid as their secondary payer. You must coordinate the benefits of these "dual-eligible" Cigna-HealthSpring customers by determining whether the customer should be billed for the deductibles, copayments or coinsurances associated with their benefit plan. Providers may not assess a Qualified Medicare Beneficiary (QMB) or QMB-Plus for Cigna-HealthSpring copayments, 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 customers. Additional information concerning Medicaid provider participation is available at [CignaHealthSpring.com](https://www.cignahealthspring.com)

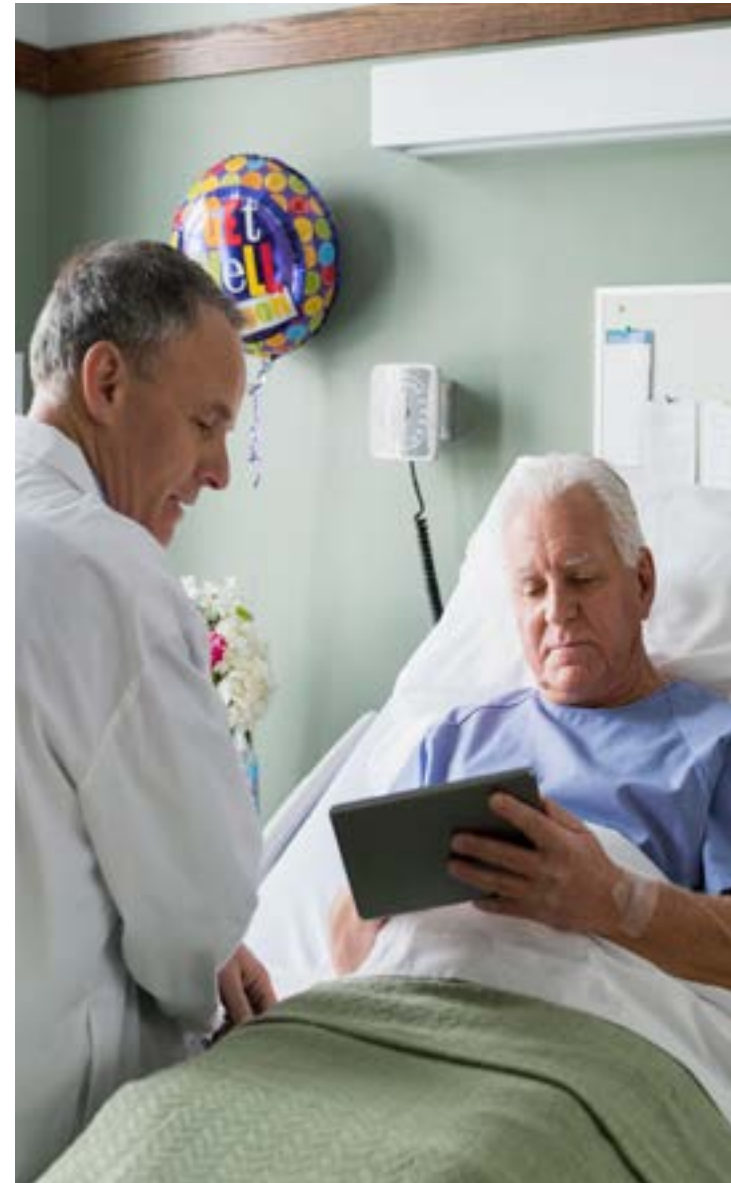
ADVANCE DIRECTIVES

The Federal Patient Self-Determination Act grants patients the 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 CMS 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 customer that the customer has executed, changed or revoked an advance directive. At the time a service is provided, the provider should ask the customer to provide a copy of the advance directive to be included in his/her medical record.

If the PCP and/or treating provider cannot, as a matter of conscience, fulfill the customer's written advance directive, he/she must inform the customer 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.



CUSTOMER HOLD HARMLESS

Participating providers are prohibited from balance billing Cigna-HealthSpring customers 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 customers or persons, other than Cigna-HealthSpring, acting on behalf of customers for Covered Services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances or deductibles for covered services in accordance with the terms of the applicable customer's Benefit Plan.

CUSTOMER GRIEVANCES

Cigna-HealthSpring customers have the right to file a complaint, also referred to as a grievance, regarding any problems they observe or experience with the health plan or a provider.

Situations for which a grievance may be filed include but are not limited to:

- › Complaints about services in an optional Supplementary Benefit package.
- › Dissatisfaction with the office experience such as excessive wait times (office wait time, check-in or check-out times exceeds 30 minutes), physician behavior or demeanor, or inadequacy of facilities.
- › Involuntary disenrollment situations.
- › Poor quality of care or services received.



- › Dissatisfaction with the office experience such as physician or office staff behavior or demeanor
- › Receiving incorrect charges or co-pays, balance billing (Reference Dual Eligibles Section). This includes situations when a customer is not properly informed of co-pays or deductibles before receiving treatment. Refer customers to contact the Customer Service number listed on their ID card for information on covered services.
- › Inadequate office space or facilities. This includes waiting and examining room space, physical appearance and cleanliness of facility.
- › Inability to reach or contact the provider or office staff via phone (i.e. unable to reach physician during regular business hours, excessive hold times, continuous busy signal, inability to leave a voicemail, not receiving a return call after leaving numerous voicemails.)

- › Lack of appointment availability (Reference Access and Availability Requirements Section)
- › Physician discharge of customer from practice without proper advanced notice.
- › Inability to obtain a timely referral from provider.

All customers have the right to be treated with respect and receive timely and adequate necessary services. If a grievance is received against you, one of your providers, your practice or facility, a Cigna-HealthSpring Representative will contact you to resolve the issue. Providers must comply with Cigna-HealthSpring's procedures for customer grievances, organization determinations, and customer appeals set forth in the Benefit Program Requirements for Benefit Programs under the Medicare Advantage Program. Grievances are monitored by Cigna-HealthSpring, excessive grievances received may result in a formal discussion, office site visit and assessment, corrective action plans and can lead up to termination.

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 plans are 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 customers enrolled in a Cigna-HealthSpring SNP. SNP customers receive additional services and coordination of care to improve their overall health. The MOC 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 customer's care plan, refer an SNP customer for an ICT meeting or participate in an ICT meeting, please contact our Case Management department. Case Management department phone numbers vary by market. Visit the "Special Needs Plan-Model of Care" section of the Provider Manual for contact information.

(For more information see the 2019 Model of Care Training for Providers at: [Cigna.com/static/docs/medicare-2019/snp-moc-training.pdf](https://www.cigna.com/static/docs/medicare-2019/snp-moc-training.pdf))





PHYSICIAN PARTICIPATION

Rules and standards

Cigna-HealthSpring maintains standards for physician participation as set forth in the provider contract and the Provider Manual. Cigna-HealthSpring may initiate a termination/non-renewal of a provider contract for failure to meet any of the participation standards. For detailed information on the rules of participation, visit the following Provider Manual sections: Credentialing and Recredentialing Program and Provider Information.

MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The terms and conditions in the Cigna-HealthSpring Provider Manual and in this regulatory booklet 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 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. In the ‘Medicare Advantage Program Requirements’ section of the online Provider Manual, you will find detailed information on:

- › Books and records; Governmental audits and inspections
- › Privacy and confidentiality safeguards
- › Customer hold harmless
- › Delegation of activities of responsibilities
- › Prompt payment
- › Subcontracting
- › Compliance with laws
- › Program integrity
- › Continuation of benefits
- › Incorporation of other legal requirements
- › Conflicts



TERMINATION PROCEDURES AND APPEAL RIGHTS

Cigna-HealthSpring provides terminating and non-renewing physicians written notification of the intent to terminate their agreement. The written notice also includes the physician's right to appeal the termination decision and request an appeal hearing as well as the process and timing for an appeal. Providers are also required to notify Cigna-HealthSpring in writing of their intent to terminate their agreement. Reference your provider agreement for notification requirements.



CREDENTIALING REQUIREMENTS

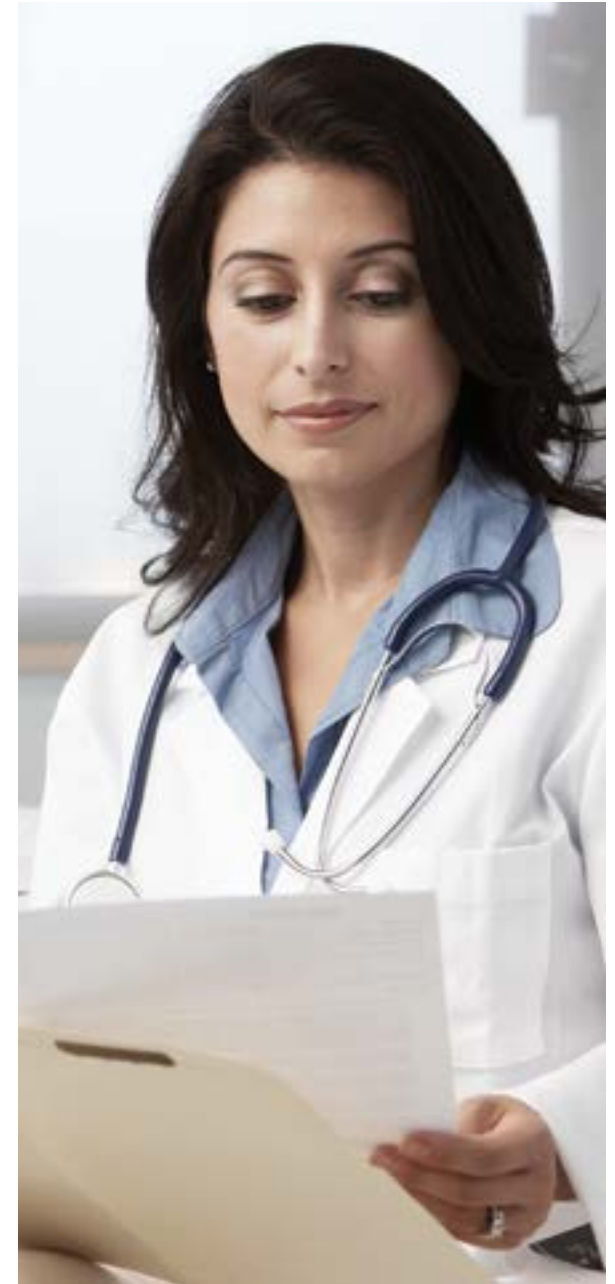
All practitioner and organizational applicants to Cigna-HealthSpring must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. Once an application has been submitted, the provider is subject to a rigorous verification process that includes primary and secondary source verifications of all applicable information for the contracted specialty(ies). 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. Cigna-HealthSpring does not financially reward providers for enrolling customers into the plan and does not make payments to providers, directly or indirectly, as an inducement to reduce or limit medically necessary services furnished to any particular customer. 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 customers 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. Providers must only offer customers assistance that results in a plan selection that is in the best interest of the customer.



PLAN NOTIFICATION REQUIREMENTS FOR PROVIDERS

Participating providers must provide written notice to Cigna-HealthSpring no less than 90 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 Service:

Provider Services: **1-800-230-6138**,
Monday-Friday: 8 a.m. - 5 p.m. CST

- › Practice address.
- › Panel status.
- › 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, changes of ownership 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.

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 information 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 patients served by the health care professional. Any health care provider wishing to contract with Cigna-HealthSpring may submit a letter of interest or Provider Application Request on the Cigna-HealthSpring website. Cigna-HealthSpring reviews all letters of interest received and either accepts or denies the provider's request. Participation decisions shall be based on a needs assessment performed related to the specialty of the provider and other related factors. Should a provider be declined participation by Cigna-HealthSpring, a written notice is provided to the provider outlining the reasoning behind the declination.

A man with curly hair, wearing a white lab coat over a blue shirt and tie, with a stethoscope around his neck. He is standing in a brightly lit room, possibly a hospital hallway, with his arms crossed and looking out a window to the right.

PROVIDER

INFORMATION

Helpful information about your role



The Provider Information section of the provider manual provides helpful information about your role as a PCP or Specialist provider. In addition, you will find detailed information on the topics below.

MEDICAL RECORD DOCUMENTATION STANDARDS

Cigna-HealthSpring has standards for customer medical records. These standards are outlined in the Provider Manual, Provider Information Section.

NOTE: Unless otherwise specifically stated in your provider services agreement, medical records shall be provided at no cost to Cigna-HealthSpring and Cigna-HealthSpring customers.

ACCESS AND MAINTENANCE OF CUSTOMER HEALTH RECORDS

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 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 Medicare Advantage Program Requirements of the Provider Manual.

SERVICES PROVIDED WITH CULTURAL COMPETENCE AND LANGUAGE SERVICES

Participating providers shall provide health care services to all customers, 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 customers 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 offers interpreter services and other accommodations for the hearing-impaired. Translator services are made available for non-English speaking or Limited English Proficient (LEP) customers. Providers can call Cigna-HealthSpring customer service at **1-800-230-6138** to assist with translator services if these services are not available in their office location. TTY dial 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 available on demand on the Cigna-HealthSpring provider website. In general, providers must ensure that:

- › They arrange for customer care 24 hours a day, seven days a week
- › They can care for customers during regular business hours as well as for urgent medical events which may occur after normal working hours.
- › Customers are able to contact providers after normal working hours (9 a.m. - 5 p.m., Monday- Friday).

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 randomly selected providers.

EMERGENCY OR DISASTER SITUATIONS

In the event of a Presidential emergency declaration, a Presidential major disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – Cigna-HealthSpring is responsible for ensuring customers have access to providers, services and medications during disasters and emergencies to avoid significant disruption.

When the state of emergency proclamation or executive order is received, a notice is posted on the Cigna-HealthSpring online provider website indicating the impacted state, counties, effective date and expiration date.

In order to ensure impacted customers have access to the services needed as of the declaration effective date, Cigna-HealthSpring:

- › Waives authorizations and referrals in full and does not require them for customers in the affected counties for Medicare covered benefits. However, authorizations and referrals are still subject to plan limitations.
- › Temporarily reduces plan-approved out-of-network cost-sharing to in-network cost-sharing amounts;

- › Waives the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee;
- › Allows Part A and Part B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A and Part B benefits must, per 42 CFR § 422.204(b) (3), be furnished at Medicare certified facilities).

NOTE:

- › A physician practicing in an affected county, but treating a MAPD patient who is visiting from an unaffected county/state and unable to leave the area will not require a referral or authorization.
- › A physician practicing in an unaffected county/state, but treating an evacuated MAPD patient who resides in an affected county will not require a referral or authorization.

Cigna-HealthSpring maintains the above in effect until the declaration is lifted or it expires. If no further notice is received, declarations expire 30 days from the effective date.



PROVIDER DIRECTORY UPDATE REQUIREMENTS

Per Chapter 4 of the Medicare Managed Care Manual, MAOs are expected to update directory information any time they become aware of changes. All updates to the online and print provider directories are expected to be completed within 30 days of receiving information.

MAOs should contact their network/contracted providers on a quarterly basis to update the following information in provider directories:

- › Ability to accept new patients;
- › Street address;
- › Phone number; and
- › Any other changes that affect availability to patients.

MAOs should contact providers using a method that is likely to achieve the highest response rate. It is not sufficient to determine that a group practice is accepting new patients.

All providers listed in hard copy or online directories must have current contracts to participate in the MA plan network. Directories provided during the AEP for the upcoming plan year are expected to fairly represent the network for the upcoming plan year.

Per these requirements, Cigna-HealthSpring is reaching out to all providers on a quarterly basis to verify the information contained in the directory through several methods:

- › If you participate with The Council for Affordable Quality Healthcare (CAQH), Cigna-HealthSpring will receive any updates made within your ProView profile to update our provider directories. Your attestation must be current in order to prevent further outreach from the plan. To submit your directory changes in ProView, you will need to take the following steps:

1. Log in to your CAQH ProView profile at <https://proview.caqh.org>.
2. New users can go to <https://proview.caqh.org> to create a secure account. Review CAQH's step-by-step videos and user guides before you start.
3. Navigate to the "Practice Locations" section to update your profile.

Review and update all the required fields to make sure patients can find you.

- Ensure you indicate current practice name, suite number, whether you are accepting new patients, etc., so the most accurate and up-to-date information is included in directories.
- Avoid duplicate addresses. If one location (e.g., a medical complex) houses multiple practices, be sure to include suite numbers to distinguish the addresses.
- Describe your practice affiliation for each location so health plans can determine whether it belongs in their directories.

- Indicate the health plans you accept at the practice-location level, since health plan participation may vary by location. You are not being asked to specify networks/products for a health plan.
- Share the phone number patients can call to make an appointment in the “Office Phone Number” field.

3. Review and Attest to your CAQH ProView profile.

Address any errors by navigating to the corresponding section and making updates.

Click “Attest” once you confirm that the status bar at the top of your profile, “Profile Data,” shows the word “Complete” in green.

If you have any questions, use the Live Chat function while you are logged into CAQH ProView or call the CAQH ProView Help Desk at 888-599-1771.

- › If you do not participate with CAQH or are a facility or ancillary provider, Cigna-HealthSpring will send a quarterly notice to each service location for a provider. Providers receiving this notification are expected to visit the Cigna-HealthSpring Provider Data Validation website at <https://chsproviderdatavalidation.com> to validate the information currently displayed within the provider directory through the following steps:

1. Login to the site using the NPI number and Last Name or Business Name contained in the notification.
 2. Review and submit changes as needed.
 3. If the information is correct and no changes are needed, check the attestation boxes verifying the information is accurate.
 4. A Thank You page will appear once changes have been submitted.
 5. Log out once all changes have been submitted.
- › Phone outreach will be completed if a provider does not attest within CAQH and/or does not attest within the Cigna-HealthSpring Provider Data Validation website on a quarterly basis.

Please submit any changes in a timely manner so we can ensure your patients are able to find you.





QUALITY IMPROVEMENT PROGRAM

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 customers 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 PROGRAM

Cigna-HealthSpring's Medical Management Program evaluates and strives to positively influence the quality of care, service, affordability, and medical outcomes of all who access the Utilization Management, Complex Case Management and Pharmacy and Behavioral Health Benefit Management programs, as well as various other specialty programs available by contract. The goal of the Medical Management Program is to promote a customer-centric approach to program delivery, facilitate the provision of quality, cost-effective medical care, promote individual education, and better the achievement of medical outcomes, all within the scope of program delivery.

Cigna-HealthSpring views an effective, integrated managed care program as one that provides contracting, utilization management and data analytics services for all significant health care benefits, including medical/surgical care, integrated behavioral health care, long-term complex case management, pharmacy management, and chronic care management. Cigna-HealthSpring's Medical Management Program, including Utilization Management activities, meets these expectations through a comprehensive collection of activities, programs and initiatives aimed at ensuring the delivery of safe, medically appropriate, high-quality, and cost-effective evidenced-based medical care with the aim of improving medical outcomes and meeting our customer's individual health goals. The specialized programs and activities that are included in the Cigna-HealthSpring Medical Management program include:

- › Utilization Management – Benefit coverage and medical necessity review of medical, behavioral health and pharmacy services;
- › Chronic Care Management, which includes Complex Case Management and Disease Management;
- › The Alegis program, which provides for physicians and Nurse Practitioners to see patients in the home when needed; and
- › Medication Therapy Management.

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 customers. For information on prior authorizations, utilization management criteria, referral management, or other utilization questions, call toll free **1-800-230-6138**, 8 am to 5 pm CST Mon thru Friday. The UM criteria can be made available upon request; in person, at Cigna-HealthSpring, or by calling **1-800-230-6138**. You may also visit the provider manual Health Services section: [Cigna.com/medicare/health-care-providers/provider-manual/2019-provider-manual](https://www.cigna.com/medicare/health-care-providers/provider-manual/2019-provider-manual) > Health Services.

CHRONIC CARE MANAGEMENT (DISEASE MANAGEMENT)

Cigna-HealthSpring's chronic care management program is a comprehensive multidisciplinary approach to the management of customers across the spectrum of care with chronic, complex and disease specific care needs. The Chronic Care Management Program is supported by a multi-disciplinary team of health care professionals with experience in the clinical management of customers with multiple chronic conditions and long-term complex medical and social support needs. Key components of the Chronic Care Management Program are to provide early identification and intervention for customers with medical, pharmaceutical or behavioral health needs who would benefit from:

- › Improved self-management skills
- › Referrals to adjunct programs
- › Complex Case Management*
- › Disease Management*

- › Assistance with coordinating plan benefits and/or community resources
- › Reduction in the frequency and/or intensity of a chronic illness exacerbation
- › Closure of gaps in preventive care measures
 - * *Not available in all markets and diseases addressed may vary between markets.*

The program's Disease Management goal is to actively work to improve the health status of customers with chronic conditions which include, but are not limited to, diabetes, congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease.

HOW CUSTOMERS ARE REFERRED FOR CHRONIC CARE MANAGEMENT

- › A PCP, specialist or other health care professional can refer customers. Customer will get a phone call or letter to review their needs and get started.
- › Cigna-HealthSpring may call customers who may benefit from the program.
- › Customers can refer themselves, or a caregiver can call us on their behalf.

Both programs are available to Cigna-HealthSpring customers who qualify.

Participation is voluntary and customers can join or leave both programs at any time.

For information, call:

1-877-562-4395, Option 1 (TTY 711) 8 a.m. - 5 p.m., Mon. - Fri. for Pennsylvania, Maryland, Delaware and Washington, D.C.

1-877-376-5193 (TTY 711) 8 a.m. - 5 p.m., Mon. - Fri. for Illinois and Indiana

QUALITY IMPROVEMENT PROGRAM

The primary objective of the Quality Improvement Program is to promote and build quality into the organizational structure and processes to meet the organization's mission of improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services. The goal of the organization is to maintain an effective quality committee structure that:

- › Fosters communication across the enterprise
 - › Collaboratively works towards achievement of established goals
 - › Monitors progress of improvement efforts to established goals
 - › Provides the necessary oversight and leadership reporting
 - › Ensures patient care and service is provided according to established goals and metrics
 - › Ensures identification and analysis of opportunities for improvement with implementation of actions and follow-up as needed
 - › Promotes consistency in quality program activities
 - › Ensures the QI program is sufficiently organizationally separate from the fiscal and administrative management to ensure that fiscal and administrative management does not unduly influence decision-making regarding organizational determinations and/or Appeals of adverse determinations of covered benefits
- › Ensures timely access to and availability of safe and appropriate physical and behavioral health services for the population served by Cigna-HealthSpring
 - › Ensures services are provided by qualified individuals and organizations including those with the qualifications and experience appropriate to service customers with special needs
 - › Promotes the use of evidence-based practices and care guidelines
 - › Improves the ability of all Cigna-HealthSpring staff to apply quality methodology through a program of education, training, and mentoring
 - › Establishes a rigorous delegation oversight process
 - › Ensures adequate infrastructure and resources to support the Quality Improvement program
 - › Ensures provider involvement in maintaining and improving the health of Cigna-HealthSpring customers, through a comprehensive provider partnership



CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES

In consultation with its participating providers, Cigna-HealthSpring adopts evidence-based Clinical Practice Guidelines (CPGs) that are based on valid and reliable clinical evidence and are appropriate to the needs of customers. CPGs are reviewed annually as national guidelines change, assuring guidelines reflect changes and/or advances in technology and scientific findings.

All contractually required covered services coordinated by Cigna-HealthSpring are in accordance with departmental policies and prevailing professional community standards. Cigna-HealthSpring provides ongoing education to providers on required clinical guideline application when clinically appropriate, and ongoing monitoring and use of the guidelines. Monitoring includes, but is not limited to, analysis and assessment of HEDIS, CAHPS, annual review of provider documentation and preventive quality indicators, as well as utilization patterns for inpatient admissions, readmissions and emergency department services. Detailed information on the following guidelines can be located in the online Provider Manual:

- › Asthma
- › Atrial Fibrillation
- › Back Pain
- › Case Management
- › Cholesterol
- › Chronic Kidney Disease
- › COPD
- › Community Acquired Pneumonia
- › Cardiovascular Disease
- › Smoking Cessation
- › Tuberculosis
- › Diabetes
- › Falls
- › CHF
- › Hypertension
- › Obesity
- › Osteoporosis
- › Peripheral Arterial Disease
- › Myocardial Infarction
- › Preventive Care
- › Family Planning and Reproductive Health
- › Pharmacy Services
- › Depression
- › Stress

PRECERTIFICATION

Precertification is a process through which a request for provisional affirmation of coverage is submitted for medical necessity review before an item or service is furnished to a beneficiary and before a claim is submitted for payment. Precertification allows for medical necessity review prior to service delivery to help prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care. The prior authorization process assures that all relevant clinical documentation requirements are met before the item or service is furnished to the beneficiary and before the claim is submitted for payment.

Cigna-HealthSpring has compiled a master list of services that require prior authorization. The list can be located in our Provider Manual and our website. If you are uncertain about the precertification requirement for a specific procedure, you may also outreach to our Provider Service Department from 7 a.m. - 6 p.m. CST at **1-800-230-6138**.

After confirming a customer's eligibility and the availability of benefits, providers should submit all supporting documentation with the request for review and subsequent reimbursement via fax to:

State	Fax Number/Contact
Alabama	FAX: 1-205-444-4263 Call: 1-800-962-3016 or 1-205-423-1222
Southern Mississippi and Northwest Florida	FAX: 1-800-872-8685 Call: 1-800-962-3016 or 1-205-423-1222
Georgia (All counties excluding Catoosa, Dade, and Walker)	FAX: 1-855-388-1452 Call: 1-866-949-7103
Tennessee, Northern Georgia and Eastern Arkansas	FAX: 1-866-287-5834 or 1-615-291-7545 (TN only) Call: 1-800-453-4464
Illinois	FAX: 1-866-287-5834 or 1-855-544-0625 (IL only) Call: 1-800-230-7298
Kansas City	FAX: 1-866-464-0707 or 1-888-545-0024 (Inpatient Admission FAX Line) Call: 1-888-454-0013
North Carolina	FAX: 1-855-500-2774 Call: 1-866-949-7099
South Carolina	FAX: 1-855-420-4717 Call: 1-866-949-7101
Texas	FAX: 1-888-856-3969 Call: 1-800-511-6932
Maryland, Delaware, Washington, DC and Pennsylvania	FAX: 1-866-464-0707 Call: 1-888-454-0013
Behavioral Health (All Markets)	FAX: 1-866-949-4846 Call: 1-866-780-8546

(visit the Health Services section of the Provider Manual)

Prior Authorization:

The Prior Authorization Department, under the direction of licensed nurses, clinical pharmacists and medical directors, documents and evaluates requests for authorization. Be sure to include the following information to ensure your request can be processed:

- › Customer name and identification number
- › Location of service (e.g., hospital or surgi-center setting)
- › Ordering Physician/Provider name
- › Servicing/attending physician name along with Tax Identification Number (TIN) or Provider Identification Number (PIN)
- › Date of service (start of care/end of care)
- › Diagnosis
- › Service/procedure/surgery description and CPT or HCPCS code
- › Clinical information supporting the need for the service to be rendered

Organization Determination Requests and Time Frames:

An organization determination is any decision (approval or denial) made by a Medicare health plan regarding payment for or authorization of requested services in whole or in part, including the type or level of service. An enrollee, an enrollee's representative or a servicing provider may request an organization determination by filing a precertification request with Cigna-HealthSpring.

Expedited Organization Determination:

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 customer's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined as expeditiously as the health condition requires, but no later than 72 hours after receipt of the request.

Expedited Organization Determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received.

Standard or Routine Organization Determination:

A standard or routine request will be determined as expeditiously as the health condition requires, but no later than 14 calendar days after receipt of the request.

Approval:

Once the Precertification Department receives the request for authorization, the request is reviewed 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. Approval notification is provided to the customer and provider.

Adverse Determination:

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. If the Medical Director makes a determination to deny or limit procedure or service, Cigna-HealthSpring will notify the facility/provider's office and the customer of the denial of service. The notice will include documentation of the original request that was denied, the reason the request was denied, and the process for appeal.

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

The criteria used in rendering the medical necessity determination is available to the provider and member upon request.

Retrospective Precertification Requests

Retrospective Precertification requests or requests submitted after care/services have been provided will not be reviewed for medical necessity unless:

- › Medically necessary services were provided to Cigna-HealthSpring customers after hours, holidays or weekends and the retrospective request with clinical information is received within 1 business day of the start of care
- › A claim was billed to an incorrect carrier and a new request, with the denied Remittance Advice (RA), is received by Cigna-HealthSpring within 2 business days of RA receipt

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



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: [Cigna.com/medicare/resources/drug-list-formulary](https://www.cigna.com/medicare/resources/drug-list-formulary).

Requests for coverage determination (CD) of pharmacy benefits may be received by the provider call center either by calling **1-877-813-5595** (7 a.m. - 8 p.m. CST Monday through Friday, or by faxing **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 [Cigna.com/healthspringdrugforms](https://www.cigna.com/healthspringdrugforms) 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 customer'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: [PDMPAssist.org/content/state-pdmp-websites](https://pdmpassist.org/content/state-pdmp-websites).

(visit the Pharmacy Prescription Benefit section of the Provider Manual)

PHARMACEUTICAL QUALITY PROGRAMS

(visit the Pharmacy Quality Programs section of the Provider Manual)

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 four 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 the 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 1-800-230-6138.

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-**Standard CMS required data elements can be found in the CMS claims processing manual located at [CMS.gov/manuals/downloads/clm104c12.pdf](https://www.cms.gov/manuals/downloads/clm104c12.pdf) 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 60 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 and 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 Claims section of the Provider Manual.)

CORPORATE COMPLIANCE PROGRAM



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. Furthermore, 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. 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 (FWA)

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

Cigna-HealthSpring
Attn: Compliance Department
PO Box 20002
Nashville, TN 37202

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

By mail:

Cigna-HealthSpring
Attn: Special
Investigations Unit
PO Box 20002
Nashville, TN 37202

By email:

specialinvestigations@cigna.com
ATTN: Cigna Medicare Operations

By phone:

1-800-667-7145

For more information on Fraud, Waste and Abuse, please refer to the Fraud, Waste and Abuse section of the Provider Manual. 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.

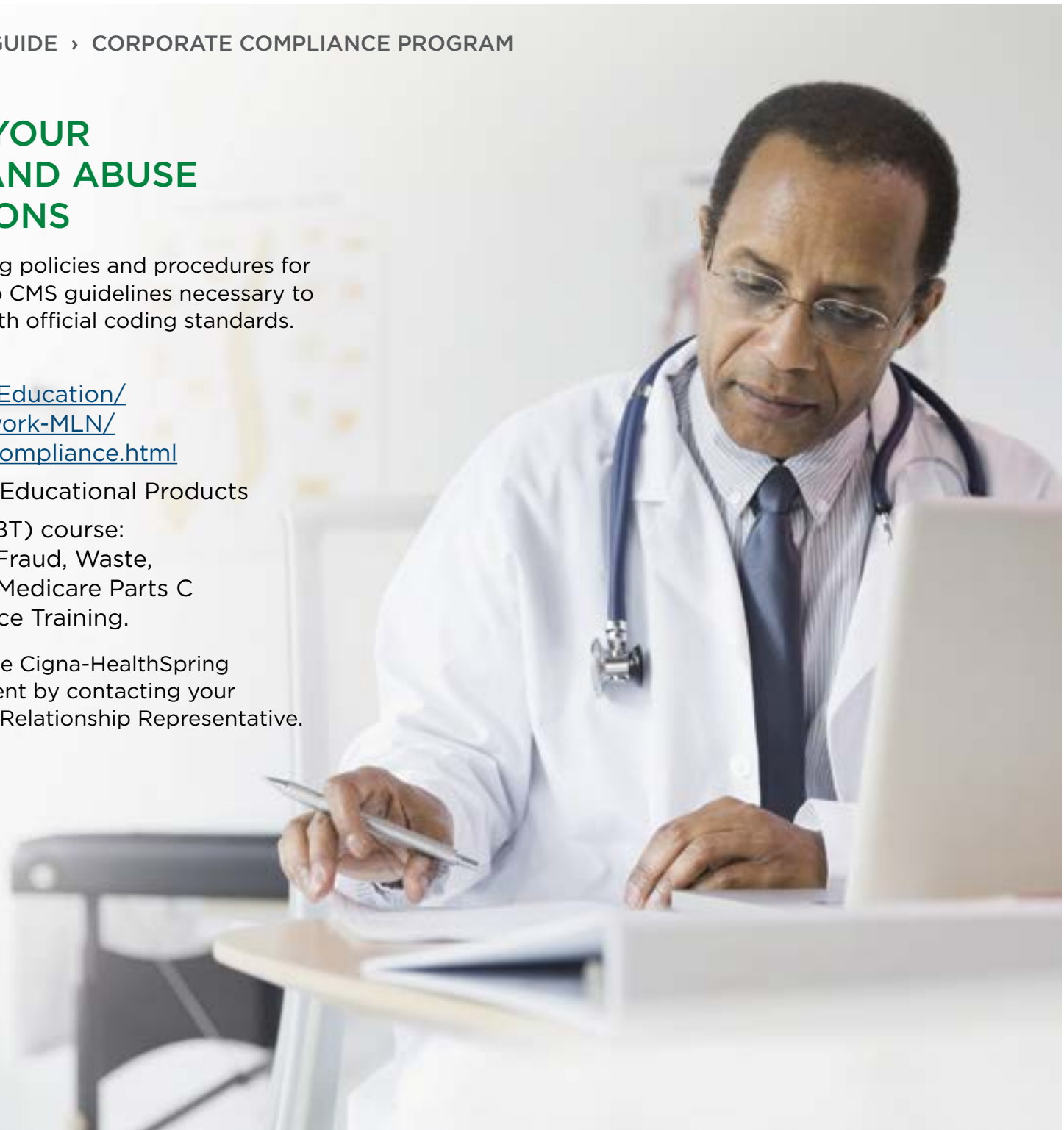
STEPS TO MEET YOUR FRAUD, WASTE AND ABUSE (FWA) OBLIGATIONS

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 online training at:

- › [CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html)
- › Select Fraud and Abuse Educational Products
- › Web-Based Training (WBT) course: Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training.

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



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Together, all the way.®

