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WORKING WITH CIGNA

ARKANSAS MEDICAL SOCIETY
OCTOBER 2019

Together, all the way.



Working with Cigna

Today's agenda

- Cigna plans
- Onboarding and demographic updates
- Quality, cost-efficiency, and Cigna Care Designation
- Cigna for Health Care Professionals website (CignaforHCP.com)
- Digital Solutions
- Claims Processing
- Appeals
- Keeping you updated
- Questions?



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CIGNA PLANS

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Cigna plans

- Cigna Choice Fund®
- Cigna Connect
- Cigna Global Health Benefits®
- Exclusive Provider Organization (EPO)
- Health Maintenance Organization (HMO)
- LocalPlus®
- LocalPlus IN Network
- Network Open Access
- Open Access Plus (OAP)
- Open Access Plus In-Network (OAPIN)
- Point of Service (POS)
- Preferred Provider Organization (PPO)
- Shared Administration Repricing (SAR)

* Some plans available with option of a health reimbursement account or health savings account (HRA/HSA).

Providing access to local, quality, cost-effective care.





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ONBOARDING AND DEMOGRAPHIC CHANGES

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The onboarding process

Step	Detail
Application intake	• State application or National Committee for Quality Assurance (CAQH) profile • Two copies of the Cigna Provider Agreement • Other supporting documents and information as requested • Cigna Physician Information form • Roster of health care professionals in your group with National Provider Identifiers (NPIs) • Sample CMS-1500 claim form • Form W-9 Request for Taxpayer Identification Number (TIN) and Certification
Application review	• Network need (specialty, access, etc.) • Review supporting documents received during application intake • Outreach for missing or inaccurate information
Credentialing verification	• Board certification, education, and training • Work history, malpractice history, and sanctions • Certificate of Insurance • Drug Enforcement Administration (DEA) license, if applicable • Physician license, as applicable • Hospital privileges or coverage, if applicable
Credentialing Committee review	• NCQA, Centers for Medicare & Medicaid Services (CMS), and state standards • Comprehensive final review and approval determination
Post-determination activities	• Notify provider of determination – approved or not approved • Load demographic data of approved providers in directory and claim systems • Send contract and welcome packet to approved provider



Expediting the credentialing process

How you can help expedite the credentialing process

- When submitting your CAQH profile or state application:
 - Make sure it's complete (answer *all* questions)
 - Sign and date within 180 days
- Attach the applicable supporting documentation
- Follow any state-specific requirements
- Sign and return both Provider Agreements
- Respond in a timely manner to requests for additional information

Most common issues

- The CAQH profile has not been updated and attested to confirm accuracy and that it's in good status, or it's not authorized for Cigna access.
- The application is missing information or a data discrepancy is identified.
- Requested information was not returned in a timely manner.
- Only one signed Provider Agreement was returned.





Demographic changes

Please notify us in writing 90 days before changing your office or billing address, telephone number, Taxpayer Identification Number (TIN), National Provider Identifier (NPI), or specialty. You can submit your demographic changes by email, fax, mail, or online. Refer to the chart below to identify the contact information for your state.*

How you can submit changes

Email: Intake_PDM@Cigna.com

Fax: 1.877.358.4301

Mail: Cigna
Provider Data Management
Two College Park Drive
Hooksett, NH 03106

Online: Cigna for Health Care
Professionals website (CignaforHCP.com
> Resources > Forms)

New requests and existing contract inquiries

Email: MedicalOnboarding@Cigna.com

Fax: 1.866.509.4544

Credentialing status inquiries

Telephone: 1.800.88Cigna (882.4462) select
the options for credentialing

Email: OnboardingStatus@Cigna.com



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QUALITY, COST-EFFICIENCY, AND CIGNA CARE DESIGNATION

Recognizing quality, cost-efficient care among providers

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Cigna Care designated physicians

are rated in both quality and
cost-efficiency



Physicians who earn the 2020 Cigna Care Designation are identified in our online directory by this unique symbol.

Online quality recognition and cost-efficiency displays

Quality recognition displays

- **National Committee for Quality Assurance (NCQA)**
recognition for:
 - Diabetes
 - Heart/Stroke
 - Physician Practice Connections
 - Patient-Centered Medical Home
 - Patient-Centered Specialty Practice
- **American Board of Medical Specialties**
- **Evidence-Based Medicine Standards**

Cost-efficiency symbols

- ★ ★ ★ **3 stars – results in the top category for cost efficiency**
- ★ ★ **2 stars – results in the middle category for cost efficiency**
- ★ **1 star – results in the lower category for cost efficiency**

Reviewed specialties

18 specialties

- Allergy and immunology
- Cardiology
- Cardiothoracic surgery
- Dermatology
- Ear, nose, and throat
- Endocrinology
- Gastroenterology
- General surgery
- Hematology and oncology*
- Nephrology
- Neurology
- Neurosurgery
- Ob-gyn
- Ophthalmology
- Orthopedics and surgery
- Pulmonology
- Rheumatology
- Urology

3 primary care physician types

- Family practice
- Internal medicine
- Pediatrics

The **21 specialty types** reviewed account for more than 87% of primary and specialty care spending based on claims data.

* Does not include radiation oncology



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CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE

CignaforHCP.com

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Patient and Plan Detail tab enhancements – plan renewal indicator and health account status



HRA, HSA, and FSA* information and plan renewal indicator

Quickly see when your patient's plan renews and if your patient has one of these health accounts.

PATIENT AND PLAN DETAIL	
Patient Detail	Plan and Network Detail
Name: John E Doe ID#: U01234567 01 Am I in-network for this patient?	Plan Type: Choice Fund HSA Open Access Plus - CareLink Plan Funding Type: ASO Plan Renews On: Calendar Year HRA: Yes HSA: Yes FSA: Yes Other Insurance: No
Gender: Female Date of Birth: 01/20/1968	Initial Coverage Date: 01/01/2002 Current Coverage From: 01/01/2002 Current Coverage To: Present Other Insurance Verified: 04/01/2018

*Health reimbursement account, health savings account, and flexible spending account

Effective November 2017 & April 2018



Patient and Plan Detail tab enhancements – network status



Am I in-network for this patient?

Click a link to quickly view the plans and networks you participate in and see if you are in network for this patient.

The screenshot shows the Cigna Patient and Plan Detail interface. The 'PATIENTS' tab is selected. The 'PATIENT AND PLAN DETAIL' section is expanded, showing patient information (Name: John E Doe, ID#: U01234567 01) and plan details (Plan Type: Choice Fund HSA Open Access Plus - CareLink, Plan Funding Type: ASO, Plan Renews On: Calendar Year, HRA: Yes, HSA: Yes, FSA: Yes, Other Insurance: No). A link 'Am I in-network for this patient?' is highlighted with an orange arrow. A pop-up window titled 'Select a Tax Identification Number (TIN) and Provider' is displayed, showing the patient's TIN (123456789) and the selected provider (ABC Hospital). The pop-up window also displays a table of the patient's contracted plans and networks, with a checkmark indicating that the patient is in-network for this patient.

Provider	Am I in-network for this patient?	Provider's contracted plan(s) & network(s)
ABC Hospital	☒ You are in-network for this patient. :	▶ Alliance ▶ GPPO ▶ HMO ▶ HMO Connect ▼ OAP - OA001 - NATIONAL OAP ← CARELINK - OA012 - LOCALPLUS SAR - OA013 - LOCALPLUS SAR ▶ OAP Connect

Notification, Referral, and Precertification Requirements tab enhancements – provider directory links



Link to provider directory

Need to search for an in-network specialist or facility when referring a patient? Now you can link to the provider directory from the patient screens.

The screenshot shows the Cigna provider directory link enhancement. The 'PATIENTS' tab is highlighted in the top navigation bar. Below it, the 'NOTIFICATION, REFERRAL AND PRECERTIFICATION REQUIREMENTS' section is expanded, showing a table of requirements for In-Network and Out-of-Network patients. At the bottom, a link to the 'Provider Directory' is highlighted in a red box.

Medical Management Level : Complete	In-Network	Out-of-Network
Failure to Notify Cigna	Applies	Applies
Precertification not approved	Applies	Applies
Additional days not approved	Applies	Applies
Emergency Service Notification	2 Business Days	2 Business Days
Outpatient Precertification	Yes	Yes
Inpatient Precertification	Yes	Yes
Continued Stay Review	Yes	Yes
Referral Required	No	No

[View Coverage Positions](#)
[View Medical Precertification Information](#)
[View Referral Requirements](#)
[View Pharmacy Prior Authorization](#)
[Provider Directory](#)
[Behavioral Directory](#)

Notification, Referral, and Precertification Requirements tab enhancements – Referral Required indicator



Referral Required

The Referral Required indicator is now available for SureFit and non-SureFit patients.

	 DASHBOARD	 PATIENTS	 CLAIMS	 REMITTANCE REPORTS	 REPORTS	 WORKING WITH CIGNA	 RESOURCES
▼ NOTIFICATION, REFERRAL AND PRECERTIFICATION REQUIREMENTS							
Medical Management Level : PHS+	In-Network	Out-of-Network					
Failure to Notify Cigna	--	50%					
Precertification not approved	--	100%					
Additional days not approved	--	100%					
Emergency Service Notification	48 hours	48 hours					
Outpatient Precertification	Yes	Yes					
Inpatient Precertification	Yes	Yes					
Continued Stay Review	Yes	Yes					
Referral Required	No	No					



Frequency and utilization data



Frequency and utilization data

For certain patient benefits, you will be able to see the number of visits used and the number remaining.



NOTIFICATION, REFERRAL AND PRECERTIFICATION REQUIREMENTS

HEALTH AND WELLNESS PROGRAMS

ABORTION SERVICES

ADULT PREVENTIVE CARE

ADVANCED RADIOLOGICAL IMAGING

CARDIAC REHABILITATION

CHILD MEDICAL CARE

CHIROPRACTIC CARE

i This benefit cross-accumulates: In-Network applies toward Out-of-Network and Out-of-Network applies toward In-Network.

PCP	In-Network			Out-of-Network		
	Amount	Met	Remaining	Amount	Met	Remaining
Coinurance	20%	--	--	30%	--	--
Maximum Visits (Per Calendar Year)	10	0	10	10	0	10

-- Utilization Data is not available for this benefit.

Specialist	In-Network			Out-of-Network		
	Amount	Met	Remaining	Amount	Met	Remaining
Coinurance	20%	--	--	30%	--	--
Maximum Visits (Per Calendar Year)	10	0	10	10	0	10

-- Utilization Data is not available for this benefit.

CignaforHCP.com – pended claims enhanced feature

OVERVIEW

Enhancement to electronically submit attachments for pended claims

What's happening?

- A new feature on the Cigna for Health Care Professionals website (CignaforHCP.com) will allow you to submit supporting documentation for pended claims that is needed to process them.
- In addition, the pend reason codes will more clearly explain what additional information is needed.

You'll be able to:

- More easily determine what documentation is needed.
- Submit requested information quickly.
- Reduce administrative costs related to pended claims, such as conducting research, calling Cigna, gathering appropriate medical records, and mailing the documentation.
- Streamline processing times of pended claims.
- Potentially avoid claim denials as the result of missing submission deadlines.

When you use this feature, we'll be able to process your pended claims more quickly.



Claim Details screen enhancements



Pended claim attachments

- Electronically submit supporting documentation for pended claims
- Pend reason codes clearly explain what additional information is needed.

Claims Search [\[- \] HIDE RESULTS](#)

You searched for:

Date of Birth: 06/25/1967 | Member First Name: Robyn | Subscriber Last Name: Fuller | Date of Service ranges from: 10/26/2011 - 4/26/2012 | [View Coverage](#)

[MODIFY SEARCH](#) [NEW SEARCH](#)

	Claim/Reference Number	Provider Generated Patient Account Number	Date(s) of Service	Date Received	Date Processed	Paid Amount	Charge Amount	Patient Responsibility	Servicing Provider	Status	Codes
	0431205000100	STP_01	01/01/2012	02/19/2012	02/22/2012	\$600.00	\$600.00	\$0.00	BABA MD/TIMOTHY W	Paid	A2...
	1707091100102	SIT835MS108B	06/28/2011	07/09/2011	In-Process	\$1,576.71	\$2,000.00	\$40.00	TECH MEDSOLUTIONS I	Pending	P1:45...

When you use this feature, we'll be able to process your pended claims more quickly.



Pended claim attachments details

Claim 1707091100102

[VIEW DETAILS IN NEW TAB](#)

Claim/Reference Number: 1707091100102

Claim Status: Pending [Upload supporting documents](#)

Claim Information

Claim/Reference Number: 1707091100102

Patient Name: ROBYN FULLER
[Coverage](#)

Provider Generated Patient Account Number: SIT835M

Service Providers: TECH M

Date Received: 07/09/2011

Date Processed: In-Process

HIPAA Status: [P1:45](#)

Payment Information

Patient Responsibility: \$40.00

[UPLOAD SUPPORTING DOCUMENTS](#)

You can upload new supporting documents for your claims.

Claim information

Claim Reference Number: 1707091100102
Claim Status: Pending
Patient Name: ROBYN FULLER
Date Received: 07/09/2011
Date Processed: In-Process
HIPAA Status: A2: 19 - Pending/In Process-The claim or encounter is in the adjudication system. Awaiting benefit determination.

Upload supporting documents

Choose a file to upload. You can upload six files for a combined maximum size of 35MB per submission. You will be able to attach the files you want, click Submit to attach them to your claim. Multiple submissions are possible.

Accepted file types: .png, .bmp, .gif, .jpg, .jpeg, .tif, .tiff, .pdf.

Upload and download times will vary depending on your Internet connection. For submissions larger than 35MB

Pending submission

Step 1: Choose and upload file

[Browse...](#)

[UPLOAD](#)

Step 2: Submit supporting files

[SUBMIT YOUR DOCUMENTS TO CIGNA](#)

Procedures

Procedure Code	Dates Of Service	Amount Charged	Allowed Amount	Amount Not Covered
27409	06/28/2011	\$0.00	\$616.71	\$0.00
78001	06/28/2011	\$0.00	\$1,000.00	\$0.00
Totals		\$2,000.00	\$1,616.71	\$2,000.00

Explanation of Remark Codes

151 - To process this claim we need to know if the patient has other medical or dental insurance. If so, please contact Customer Service at the phone number on the back of your ID card. You can also mail the information to the address shown on this EOB or go to www.mycigna.com to enter the information on line.

About attachments

You can:

- Send up to six files at a time, for a total file size of 35 MB. (The maximum size for an individual file is 10 MB.)
- Submit files in any of these formats: BMP, GIF, JPEG, PDF, PNG, or TIF.
- Easily convert a Microsoft file into a PDF. Note that PDF files cannot be more than 998 pages.
- Name files with a maximum of 128 characters, including the file extension.



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DIGITAL ID CARD TOOL

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Accessing the digital ID card tool

PATIENT SAVINGS START IN NETWORK
Small changes can mean big savings for patients. Learn more about the value of referrals. [WATCH VIDEO](#)

[COACH BY CIGNA MOBILE APP](#) [THE LATEST NEWS](#) [SAMPLE ID CARDS](#)

[BALANCED ALLIANCES](#) [BENEFITS OF JOINING THE CIGNA NETWORK](#) [DIRECTORY UPDATES AND CHANGES](#)

PATIENT INFORMATION AT YOUR FINGERTIPS
CignaforHCP.com provides real-time patient data and more. [VISIT NOW](#)

[CREDENTIALING AND RE-CREDENTIALING](#) [CIGNA DENTAL RESOURCES](#) [ATHENAHEALTH 2016 PAYVIEW REPORT](#)

HEALTH CARE REFORM
Dive into health care reform. Find out what it means for your practice. [Learn More](#)

On
Cigna.com

CIGNA FOR HEALTH CARE PROFESSIONALS
An easy way for medical, behavioral, and dental health care professionals to work with Cigna.

Login
User ID:
Password:
[LOGIN](#)
[Forgot User ID](#) | [Forgot Password](#)

How can we help you today?
[Review coverage policies](#)
Learn how to interpret Cigna standard health coverage plan provisions. Access the medical coverage policies.
[Review clinical reimbursement and payment policies](#)
Find appeal policies, claim editing procedures, and laboratory and reimbursement information. For the most recent medical necessity review list, precertification policies, and modifier policies, log in to CignaforHCP.com.
[Find a form](#)
Access the forms you need for authorizations, referrals, filing or appealing claims, or changing information about your office.
[Submit a claim to Cigna](#)
Get quick tips and easy-to-follow instructions for submitting claims electronically to Cigna.
[Search the health care professional directory](#)
Find a health care professional in your patients' network. Select a directory, and find network-participating health care professionals that best fit your patients' needs, based on their coverage.
[Explore medical resources](#)
From newsletters, to wellness programs, to Cigna medical plans, and more, this is your source for information.
[Explore behavioral resources](#)
Find guidelines, materials and tools that can help you work more efficiently with Cigna.
[Looking for something else?](#)
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[MOST COMMON ID CARDS](#)

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On
CignaforHCP.com



Using the digital ID card tool

Key features

- **Interactive, easy-to-navigate tool on Cigna.com**
- Quick online access to patient ID card samples, plan details and requirements, direct links to the provider directory, Provider Digital Solutions options, myCigna mobile app overview, important contacts, and more.

View tool



INTRODUCING AN EASIER WAY TO VIEW SAMPLE CIGNA ID CARDS

The Quick Guide to Cigna ID cards interactive digital tool



The tool is easy to use:

- To access the Quick Guide to Cigna ID Cards digital tool, go to [Cigna.com](https://cigna.com) > Health Care Professionals > ID Card Details or go to [CignaforHCP.com](https://cignaforHCP.com) > View Sample ID Cards.
- To view sample ID cards for only certain plan types, click "Filter Card By Category." Select one or more plan types – such as Managed Care Plans or Individual & Family Plans – from the categories that appear.
- Choose the image that most closely matches your patient's ID card.
- For more details about a section of the card, hover over each number shown on the card, or read the key on the right-hand side of the screen.
- To see the reverse side of the card, click "View the Back."
- To read more about the plan associated with the ID card, click "About This Plan."
- To view a different sample ID card, Click "View Another Card Type."

On every screen of the digital ID card tool, you can also click a green tab for "More Information" about:

- The myCigna Mobile app
- More ways to access patient information when you need it
- Important contact information








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Patient digital ID card tool



View patient's ID card

You can now view your patient's ID card online, and print a copy.

Cigna DASHBOARD **PATIENTS** CLAIMS REMITTANCE REPORTS REPORTS WORKING WITH CIGNA RESOURCES

Coverage Details Estimate Costs

SCROLL TO: » [dropdown]

ELIGIBILITY AS OF DATE CAN BE TWO YEARS PRIOR OR UP TO 30 DAYS IN THE FUTURE » 07/11/2018 [calendar icon]

UPDATE

Patient ID: U01234567 Coverage From: 01/01/2002
Account #: 123456 Account Name: ABC Group
Coverage To: Present
Plan: Choice Fund HSA Open Access Plus - CareLink
[View patient's ID card](#)

TEMPORARY ID CARD

Medical ID Card
Please note: Temporary cards may not contain all the information on the actual ID card and they expire in 14 days or on the member's current coverage termination date.

Front	Back
Issue Date: 07/21/2018 Cigna For coverage info: Customers: Review your coverage on the myCigna website or mobile app, or call 800-902-4402. John E Doe Subscriber ID: U01234567 01 Cigna SureFit HRA Group Number: 123456 Coverage Effective Date: 06/01/2017 RoBIN: 1123456 RuPCN:	You may be asked to present this card when you access care. This card doesn't guarantee coverage. You must comply with all terms and conditions of the plan. Willful misuse of this card is considered fraud. Hospital Admission: Prior to any non-emergency hospital admission, you or your doctor must call the toll-free Customers and Health Care Professionals number shown below to request "precertification". In the case of an emergency, you, your family, or your doctor must call within 48 hours of hospital admission. Failure to contact Cigna will affect your coverage. In an Emergency: Seek care immediately. Go directly to the nearest emergency facility or call 911. Health Care Professionals: Visit www.CignaforHCP.com or call 800-902-4402. Customer Support Number: 1.800.424.2111 (24 hours a day, 365 days a year) Send Medical Claims to: Cigna PO Box 108001 Chattanooga, TN 37422-8001

PRINT

Effective July 2018



Better health.

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REAL TIME BENEFIT CHECK

Help patients avoid surprises at the pharmacy

Together, all the way.®



Current prescribing challenges

Patient



Sticker shock,
treatment delays

Provider



Lack of information,
administrative burdens

Plan



Higher costs, lower
performing benefit designs,
lower net promoter scores

Pharmacy



Abandoned
prescriptions



Opportunities to reduce stakeholder

frustration and
unintended consequences

Cigna's real time benefit check (RTBC) answers these needs



Provide **patient-specific** prescription benefit information at the **point of care**



Real customer needs satisfied in real time

- ✓ Patient **cost shares**
- ✓ Patient **channel options** and their cost (e.g., 30 day at retail, 90 day at mail)
- ✓ **Therapeutic alternatives** with patient costs displayed to providers
- ✓ Patient specific **coverage status and flags** (e.g. prior authorization, step therapy, quantity limits)

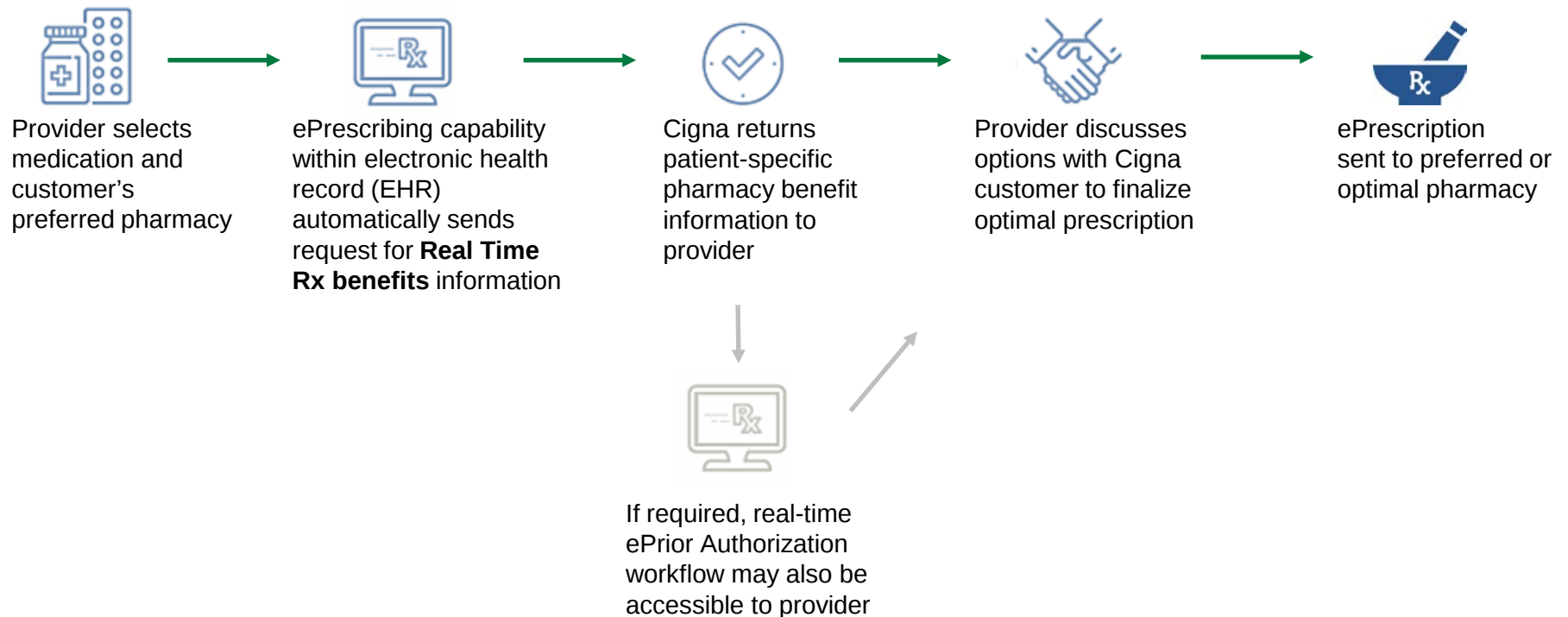


As a result, RTBC allows the provider and their patient to discuss available options, including costs, before the patient leaves for the pharmacy, avoiding surprises at the pharmacy counter.

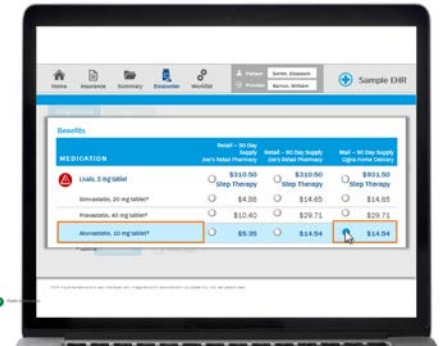


How RTBC works

RTBC delivers actionable prescription information through an automatic service within providers' existing ePrescribing workflow



Key RTBC takeaways



> If your organization has RTBC up and running:

- Ask about awareness
- Determine whether providers are actually ‘seeing’ the RTBC responses in the EMR system during the ePrescribing process
- Obtain feedback on how useful the RTBC information is and whether it has resulted in meaningful conversations with customers and changes to lower cost alternatives

> If your organization does not have RTBC operational:

- Ask about awareness
- Confirm the EMR system used by the group, RTBC capability status, and future plans/timing to implement
- Obtain feedback on requirements for RTBC activation from the group’s EMR vendor



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PROVIDER DIGITAL SOLUTIONS

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Precertification on CignaforHCP.com

You can access the new precertification page on CignaforHCP.com > Learn about the precertification process, or go to CignaforHCP.com/precertification.

Precertification



PRECERTIFICATION GUIDELINES

Precertification can be complicated. Knowing the right place to start can make a big difference.

Below you will find when and where to submit precertification requests to Cigna and Cigna's national ancillary vendors for the following:

- Medications
- Medical Procedures
- Durable Medical Equipment
- HI-Tech Imaging
- And other services

You'll also find answers to some of the most [frequently asked questions](#) related to precertification.

First, determine if precertification is required

To view the complete list of services that require precertification of coverage:

- [Log in to CignaforHCP.com](#)
- Click on "Precertification Policies" under "Useful Links"

Not registered yet? [Go to CignaforHCP.com](#) and click on "Register Now"

Please note: Precertification of coverage is not required for emergency services. However, emergency services that result in an inpatient hospital admission must be reported within one business day of the admission unless dictated otherwise by state mandate.

Then, follow the service specific precertification process

Medications

To request prior authorization for medications, please visit [PromptPA](#).



CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE

Method one

Together, all the way.





Cigna for Health Care Professionals website

Does my patient's plan require precertification?



Log in to the Cigna for Health Care Professionals website (CignaforHCP.com)

Search for your patient. Once on the Coverage Details page, scroll down to the Notification, Referral and Precertification Requirements section.



PLAN LEVEL COINSURANCE, DEDUCTIBLES AND MAXIMUMS

PRIMARY CARE PHYSICIAN NAME AND ADDRESS

NOTIFICATION, REFERRAL AND PRECERTIFICATION REQUIREMENTS

Medical Management Level : PHS	In-Network	Out-of-Network
Failure to Notify Cigna	Applies	Applies
Pre-certification not approved	Applies	Applies
Additional days not approved	Applies	Applies
Emergency Service Notification	2 Business Days	2 Business Days
Outpatient Precertification	Yes	Yes
Inpatient Precertification	Yes	Yes
Continued Stay Review	Yes	Yes
Referral Required	Yes	Yes

[View Coverage Positions](#)
[View Medical Precertification Information](#)
[View Referral Requirements](#)
[View Pharmacy Prior Authorization](#)



Cigna for Health Care Professionals website

Does this outpatient service require precertification?



if coverage details indicate that outpatient services require precertification:

Click View Medical Precertification Information. This will bring you to the Precertification Policies page.

▼ NOTIFICATION, REFERRAL AND PRECERTIFICATION REQUIREMENTS

Medical Management Level : PHS+	In-Network	Out-of-Network
Failure to Notify Cigna	--	50%
Precertification not approved	--	100%
Additional days not approved	--	100%
Emergency Service Notification	48 hours	48 hours
Outpatient Precertification	Yes	Yes
Inpatient Precertification	Yes	Yes
Continued Stay Review	Yes	Yes
Referral Required	No	No

[View Coverage Positions](#)

[View Medical Precertification Information](#)

[View Referral Requirements](#)

[View Pharmacy Prior Authorization](#)

[Provider Directory](#)

[Behavioral Directory](#)



Cigna for Health Care Professionals website

Master Outpatient Precertification List

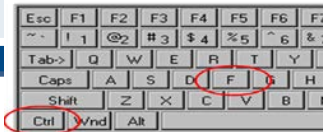
Precertification Policies

- Learn about our precertification policies, requirements and affected procedures
- **Master Outpatient Precertification List** a detailed listing of procedures and corresponding codes.
- Oncology Drugs Requiring Precertification through eviCore Healthcare
- R21 - Precertification Reimbursement Policy
- Notification of Changes to Precertification List
- Dialysis Prenotification
- Precertification Policy
- Medicare Primary — Precertification Policy
- Obtaining Precertification
- Services Requiring Precertification - For APWU patients requiring precertification, call 1.800.582.1314.
- Outpatient – Personal Health Solutions Plus (PHS+)
- Failure to Obtain Precertification

Click Master Outpatient Precertification List

This is a searchable, detailed listing of procedures and corresponding codes for services that require precertification.

To search for a procedure code, click Ctrl + F.



MASTER PRECERTIFICATION LIST

For Providers

August 2018

Code	Code Description	Addition / Removal
Revenue Code 0333	Radiology-Therapeutic and/or Chemotherapy Administration-Radiation Therapy	Precertification delegated to eviCore healthcare (formerly CareCore) National Radiation Therapy Program; Added 02/27/2016
Revenue Code 0335	Intensive outpatient services-psychiatric	Added 08/27/2015



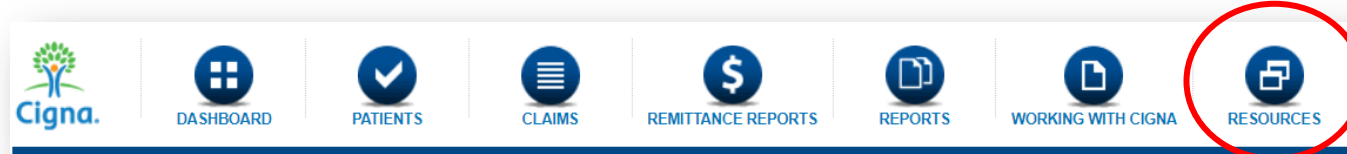
Cigna for Health Care Professionals website

General precertification information and the Master Outpatient Precertification List



From the Resources tab, you can also find:

- General precertification information. Click Precertification.
- The Master Outpatient Precertification List. Click Reimbursement and Payment Policies > Precertification Policies > Master Outpatient Precertification List.



BROWSE RESOURCES DOCUMENTS



Precertification

Learn how to properly request precertification for medical procedures, delegated ancillary vendors, and medications.



Medical Resources

Explore our newsletters, case management and wellness programs, medical plans, and more.



Pharmacy Resources

Find information, drug lists and prior authorization forms.



Behavioral Health Resources

Review treatment guidelines for level of care determinations and clinical practice.



Behavioral Management

Find the most up-to-date working to document contract.



Reimbursement and Payment Policies

Find appeal policies, claim editing procedures, laboratory, and reimbursement information.



Coverage Policies

Know how to interpret our standard health coverage plan provisions.



Forms Center

Easily find the right form for the right purpose.



Reference Guides

Review reference guides to help make doing business with Cigna easier.



eCourses

Learn how Cigna can help you work easier.



ELECTRONIC DATA INTERCHANGE

Method 2

Together, all the way.



Electronic data interchange – eligibility and benefits 270/271 transaction

Does this service category require precertification?



To find the precertification indicators on the 271 response:

Look in the eligibility and benefit (EB) segment for each Service Type Code (STC). The indicator will be shown in the second from the last field.

Please see example below.

```
EB*C*IND*98***23*0.00***N*Y~  
MSG*Medical~  
MSG*Telehealth through contracted vendor~  
III*ZZ*99~  
EB*C*IND*98***23*0.00***N*W~  
MSG*Medical~  
MSG*PCP~  
MSG*Specialist~  
MSG*Behavioral~  
MSG*Drug Abuse~  
MSG*Psychiatric~  
MSG*Alcohol Abuse~
```

EB = Eligibility or benefits

98 = Service type code for physician office visit

N = Precertification is not required for service type code 98



Clear Claim Connection™ (1 of 3)

On CignaforHCP.com:

1. Hover over claims
2. Click on View Claim Coding Edits
3. Window will come up with Agreement
4. Click I ACCEPT
5. Sample screen will appear to enter patient information (see below):

The screenshot shows the CignaforHCP.com homepage with a navigation bar containing icons for Dashboard, Patients, Claims, Remittance Reports, Reports, Working with Cigna, and Resources. The 'Claims' icon is highlighted. Below the navigation bar is a 'Claims Search' section with two tabs: 'PATIENT INFORMATION' and 'CLAIM/REFERENCE NUMBER'. The 'PATIENT INFORMATION' tab is active. It contains several input fields: 'Date of Service' (with a dropdown menu), 'From' (02/23/2016), 'To' (08/23/2016), 'Patient ID' (910114777), and 'Patient Date of Birth' (05/01/1960). A 'SEARCH' button is at the bottom. A dropdown menu for 'Select Providers/Groups' is open, showing a list of providers including 'NEW ENGLAND MEDICAL CENTER', 'MEDSOLUTIONS INC LOWTECH', and 'SAN ANTONIO COMMUNITY HOSPITAL'.

Claim Coding Edits

You are now leaving the Cigna for Health Care Professionals site.

Links to other websites are provided for your convenience. Cigna is not responsible for their content or accuracy.

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The non-Cigna website's privacy practices may be different than Cigna's practices.

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10. Cigna has the right to modify or terminate Provider's access to the C3 Software at any time or for any reason, including but not limited to Provider's violation of any terms of this Agreement.

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By clicking "I accept" below you are agreeing to the terms and conditions above. If you do not want to agree to these terms, click "I do not accept".

Click "I ACCEPT."



Clear Claim Connection (2 of 3)

Sample screen will come up where you can enter customer's information.

**Clear Claim Connection™**

McKesson Edit Development Glossary About Help Logoff

Clinical Edit Clarification

1 of 1 Clarifications

Printable Version

New Claim Current Claim Review Claim Audit Results

Inquiry:

Why is this procedure disallowed?

Procedure	Description
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:- A PROBLEM FOCUSED HISTORY;- A PROBLEM FOCUSED EXAMINATION;- STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESEN
10040	ACNE SURGERY (EG, MARSUPIALIZATION, OPENING OR REMOVAL OF MULTIPLE MILIA, COMEDONES, CYSTS, PUSTULES)

Response:

CMS often publishes coding instructions in its rules, manuals, and notices. Physicians must utilize these instructions when reporting services rendered to Medicare patients. The CPT Manual also includes coding instructions which may be found in the "Introduction", individual chapters, and appendices. In individual chapters the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter, or after specific CPT codes. Physicians should follow CPT Manual instructions unless CMS has provided different coding or reporting instructions. The American Medical Association publishes CPT Assistant which contains coding guidelines. CMS does not review nor approve the information in this publication. In the development of NCCI edits, CMS occasionally disagrees with the information in this publication. If a physician utilizes information from CPT Assistant to report services rendered to Medicare patients, it is possible that Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries may utilize different criteria to process claims.

Therefore, this procedure is not recommended for separate reimbursement.

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Click "Review Claim Audit Results."

Clear Claim Connection (3 of 3)

Note that one claim will be accepted, and one claim will not. To determine why the claim will not be accepted, click “Disallow.”

**Clear Claim Connection™**

McKesson Edit Development Glossary About Help Logoff

Claim Audit Results

Gender: Male
Date of Birth: 1/1/1970
ICD Code Set: ICD-9

Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.

Line	Procedure	Description	Mod 1	Mod 2	Mod 3	Mod 4	Qty.	Date of Service From	Date of Service Thru	Place of Service	Line Diag. 1	Line Diag. 2	Line Diag. 3	Line Diag. 4	RVU	Pay %	Recommendation
1	10040	ACNE SURGERY					1	01/06/2014	01/06/2014	11 (Office)					n/a		Allow
2	99212	OFFICE/OUTPATIENT VISIT EST					1	01/06/2014	01/06/2014	11 (Office)					0		Disallow

New Claim Current Claim

The results displayed do not guarantee how the claim will be processed.

The next screen provides a detailed explanation.

**Clear Claim Connection™**

McKesson Edit Development Glossary About Help Logoff

Clinical Edit Clarification

1 of 1 Clarifications

Printable Version

New Claim Current Claim Review Claim Audit Results

Inquiry:
Why is this procedure disallowed?

Procedure	Description
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:- A PROBLEM FOCUSED HISTORY;- A PROBLEM FOCUSED EXAMINATION;- STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM (S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESEN
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Therefore, this procedure is not recommended for separate reimbursement.



CIGNAFORHCP.COM AND THIRD-PARTY ADMINISTRATORS

Payer Solutions and Shared Administration Accounts

Together, all the way.



Identifying the type of account – payer solutions or shared administration

Patient Search

[MODIFY SEARCH](#)[NEW SEARCH](#)[\[-\] HIDE RESULTS](#)

PATIENT RESULTS AS OF 04/25/2019

	Patient ID	Date of Birth	Patient Last Name	Patient First Name	Coverage From	Coverage To	Coverage Status	Account	Notes
	N3			Allan	09/01/2011	Present	Shared Administration/ Alliance Patient	BENEFIT PLAN	
	24			Shelia	01/01/2018	Present	Payer Solutions		



Patient search results

When searching for a patient, the Coverage Status column indicates if the plan is Shared Administration or Payer Solutions.



Identifying a patient with third-party administrator (TPA) coverage

Martha Brown

[VIEW DETAILS IN N](#)

COVERAGE DETAILS

ESTIMATE COSTS

VIEW CLAIMS

[DETACH](#) | [USEFUL LINKS](#) | [PRINT](#)

ELIGIBILITY AS OF: 04/08/2019



Patient ID: U92810582 01
Account #:

Coverage From: 07/01/2013
Account Name:

Coverage To: Present
Plan:

- TZ RESOURCEONE ADMINISTRATORS is responsible for administering various aspects of this patient's plan, which may include claim processing, utilization management, eligibility verification. For additional coverage information, call 800.967.2077.
- This is not a guarantee of coverage or that the coverage amounts shown will remain unchanged until the date services are rendered. Any claim submitted is subject to a provisions including eligibility requirements, exclusions, limitations and state mandates. Coverage will be determined on the basis of the facts existing when services are rendered.



The Patient Eligibility and Benefits page

Under the coverage details section when the patient's benefits are not managed by Cigna, the website will indicate the TPA name and phone number.



CignaforHCP.com > Resources > Medical Resources > Medical Plans and Products

Resources >> Medical Resources >> Medical Plans And Products

Medical Plans And Products

An overview of more than 10 Cigna medical plans including indemnity, HMO and network, Medicare, open access, PPO and more.

Document Title	Document Type	Document Size	Last Updated
Cigna Choice Fund®	Online Resource	--	04/12/2016
Cigna Medicare Rx®	Online Resource	--	04/19/2016
Cigna-HealthSpring Medicare Advantage Employer Plans-Phoenix 2017	PDF	572KB	02/28/2017
Cigna-HealthSpring Medicare Advantage Individual Plans 2017	PDF	457KB	02/09/2017
Cigna Indemnity Vision Care	Online Resource	--	
Cigna Medicare Surround®	Online Resource	--	09/16/2014
Cigna Network Vision	Online Resource	--	04/12/2016
Cigna Vision Plans	Online Resource	--	04/12/2016
Cigna Vision PPO	Online Resource	--	04/12/2016
HMO and Network	Online Resource	--	
Cigna SureFit®	Online Resource	--	05/25/2018
Indemnity	Online Resource	--	
LocalPlus®	Online Resource	--	04/12/2016
Open Access Plus	Online Resource	--	
Open Access Plus plans, administered by QualCare	Online Resource	--	02/13/2018
Payer Solutions	Online Resource	--	08/02/2018
Point of Service (POS)	Online Resource	--	
Preferred Provider Organization (PPO)	Online Resource	--	
Seton Insurance Company plans	Online Resource	--	12/15/2016
Shared Administration	Online Resource	--	12/05/2018
Strategic Alliances	Online Resource	--	03/01/2019
Viant/Beech Street Client Listing	Online Resource	--	



Resource pages exist for each plan type.

Each page has a link to a list of active Payer Solutions and Shared Administration accounts. The lists contain contact information including TPA website links, if available.



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CLAIMS PROCESSING

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Submitting attachments, and corrected and secondary claims

Electronic claims with attachments:

To submit electronic claims with attachments, including high-dollar itemized claims

- In the 837: Loop 2300 PWK (paperwork) segment of the claim, and indicate that notes will be faxed or mailed. (Do not put the actual notes in the segment).
- Include in the notes:
 - Patient name
 - Total amount billed
 - Patient Cigna ID
 - Health care professional Taxpayer Identification Number (TIN)
 - Date of birth
- Fax medical attachments to:
 - Cigna high-dollar claims 1.859.410.2421
 - Cigna general claims (non-high dollar claims) 1.859.410.2422

Corrected claims submission:

- In the Claim Frequency Type Code in Loop 2300, Segment CLM05, specify the frequency of the claim. (This is the third position of the Uniform Billing Claim Form Bill Type.)
- Use one of these codes:
 - 1 – Original (admit through discharge claim)
 - 7 – Replacement (replacement of prior claim)
 - 8 – Void (void or cancel of prior claim)



Submit **corrected claims** electronically.

- Use the Claim Frequency Type Code in loop 2300, segment CLM05, to specify the frequency of the claim. (This is the third position of the UB04 bill type.)
- Use one of the following codes to indicate the claim type:
 - 1 – Original (admit through discharge claim)
 - 7 – Replacement (of a prior claim), include Payer Claim Control # in segment REF*F8
 - 9 – Void (or cancellation of prior claim), include Payer Claim Control # in segment REF*F8

When a corrected claim is submitted, you will receive a “duplicate to claim already in process” denial message and the corrections will be applied to the original claim.



Avoid potential claim payment delays.

Frequent **claim denial reasons**:

- **Duplicate claim submissions**
 - claim already in process
 - claim previously processed
- **Missing information**
 - Medicare explanation of benefit (EOB)
 - Other insurance EOB
 - Revenue codes itemization

Carefully review the message(s) on your explanation of payment (EOP) to determine the reason for a denial of services or a payment reduction. If you have questions about a denial, please call the Cigna Customer Service number on the patient's ID card.





Requests for additional information

Respond to **requests for information** timely.

Cigna routinely evaluates claims for coding, billing accuracy, and appropriateness and may request supporting claim payment information such as:

- An itemized bill
- Medical records

Once the claims review is completed, we will:

- process and reimburse the claim accordingly
- issue an explanation of payment
- send you a letter explaining any charges determined to be not payable

Visit the secure Cigna for Health Care Professionals website for a list of the Not-Payable Reason Codes, including descriptions and reconsideration criteria, at CignaforHCP.com > Resources > Reimbursement and Payment Policies > Clinical Claim Review Not Payable Reason Codes.



Payer solutions – points of interaction

Claim flow

- Claims should be submitted to Cigna (payer ID 62308 or to the claims mailing address on the patient's ID card
- Cigna prices the claims based on the network contracted rates
- The priced claim is then forwarded to the payer for payment based on the patient's eligibility and benefits
- The payers then remit payment following contractually agreed upon turnaround requirements

Clinical and contract-related appeals

- Appeals of clinical denials should be sent to Cigna using the contact information supplied in the denial letter(s)
- Appeals of application of contract rates should go to the address on the patient's ID card

Contact the payer* for:

- Eligibility
- Benefits
- Precertification
- Claims status
- Non-pricing appeals

* The contact phone number is located on the patient's ID card

Contact Cigna* for:

- Reimbursement issues
- Pricing appeals
- General contract questions

* The contact phone number for Cigna is 1.888.663.8081



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PEER-TO-PEER PROCESS AND APPEALS

Together, all the way.®



Peer-to-peer process



Request a peer-to-peer review before filing an appeal. It may result in a reversal of a previous coverage decision.



This review provides an opportunity to provide additional clinical information.



If the peer-to-peer review does not result in a revised coverage decision, you may still submit an appeal through our appeal process.



Initiate by calling:
1.800.88Cigna
(882.4462), option 3.
For individuals with
GWH-Cigna or "G"
ID cards, call
1.866.494.2111.



To file an appeal

Appeals

- Our process offers a single level of appeal.
- Appeals must be initiated within 180 calendar days of the date of the initial payment or denial decision.
- Decisions are made and communicated within 60 days of appeal receipt.
- Arbitration may be used as a final resolution step after the internal Cigna process is complete.
- CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies > Claim Appeals > Appeal Policy and Procedures for Health Care Professionals.

Note:

Appeals policies may vary by state; statute supersedes Cigna policy. For details on state-specific dispute policies, see the claim appeal information posted on the website.

Request for Health Care Professional Payment Review



BEFORE PROCEEDING, NOTE THE FOLLOWING:

- Corrected claims should be submitted to the claim address on the back of the patient's Cigna ID card. If the claim in question has had no payments to date and/or you are submitting additional information for the initial review of payment, please forward to the address on the back of the customer's identification card.
- Fee Schedule or reimbursement terms for multiple patients do not require individual appeals. Contact Cigna's Customer Service Department for further assistance. If you are a contracted Health Care Professional and you feel your contract is being inappropriately applied, please contact your Provider Services Representative at Cigna.

STEP 1:

Contact Cigna's Customer Service Department at the toll-free number listed on the back of the patient's Cigna ID card to review any adverse determinations/payment reductions. If a Customer Service representative is unable to change the initial decision, you will be advised at that time of your right to request an appeal.

STEP 2:

Complete and mail this form and/or appeal letter along with all supporting documentation to the address identified in Step 3 on this form. Your appeal should be submitted within 180 days and allow 60 days for processing your appeal, unless other timelines are required in your Provider Agreement or by state law.

REQUESTS FOR REVIEW SHOULD INCLUDE:

1. This completed form and/or an appeal letter requesting an appeal review and indicating the reason(s) why you believe the claim payment is incorrect and should be changed. If submitting a letter, please include all information requested on this form. If only submitting a letter, please specify in the letter this is a Health Care Professional Appeal.
2. Include a copy of the original claim and the Explanation of Payment (EOP) or Explanation of Benefits (EOB), if applicable.
3. For reviews involving a previous clinical denial, such as denied hospital days, level of care, medical necessity or services denied for no prior authorization, supporting documentation should include a narrative describing the situation, an operative report and medical records, as applicable.

PLEASE COMPLETE:

Are you contracted with Cigna? ☐ Yes ☐ No Tax ID #: _____ NPI #: _____

Have services been rendered? ☐ Yes ☐ No

If no, and these services require prior authorization, we will resolve your appeal request for benefit coverage as expeditiously as possible and within the time permitted by applicable law.

Please check the issue that best describes your appeal. The initial decision was related to:

- ☐ Mutually exclusive, incidental or bundling procedure code denial
- ☐ Your Cigna contract and the Fee Schedule or reimbursement terms
- ☐ Modifier reimbursement. List modifier(s): _____
- ☐ Inpatient Facility denial (level of care, length of stay, delayed treatment day)
- ☐ Experimental/Investigational procedure
- ☐ Medical necessity of the service
- ☐ Timely claim filing (without proof)
- ☐ Pre-certification/Authorization not obtained
- ☐ Request for in-network benefits
- ☐ Benefit plan exclusion or limitation
- ☐ Maximum Reimbursable Amount
- ☐ Non Participating Anesthesiologist, Radiologist, or Pathologist requesting in-network benefits
- ☐ Other (please indicate): _____

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844767a Rev. 06/2013 (Continued on next page) ©2013 Cigna





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NATIONAL ANCILLARIES

Lowering costs without sacrificing quality

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providing your patients with

quality and cost-effective care

Accessible

Quality focused

Cost efficient

Patient oriented

National Ancillary Programs*

Service	National ancillary providers*
Chiropractic	American Specialty Health®
Dialysis	• Davita • Fresenius
Durable medical equipment, home health care, infusion therapy	CareCentrix
Hearing	Amplifon Hearing Health Care
High-technology radiology and diagnostic cardiology	eviCore healthcare
Integrated Oncology Management Program	eviCore healthcare
Laboratory**	• LabCorp® • Quest Diagnostics®
Musculoskeletal and pain management	eviCore healthcare
Orthotics and Prosthetics	Linkia
Physical and occupational therapy	American Specialty Health®
Radiation therapy	eviCore healthcare
Sleep management services	CareCentrix
Vision services	Vision Services Plan

*List is not all-inclusive of every national ancillary provider. Ancillary providers do not manage services in all states and markets.

**We currently contract with numerous local and national laboratories, including LabCorp® and Quest Diagnostics, Inc. and other reference, pathology, genetic, and esoteric labs, to provide quality laboratory services at in-network, cost-effective rates.



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KEEPING YOU UPDATED

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Coverage policy updates

policy

and

coverage

updates

May 2019

- Infusion and Injection Administration Services
- Pass-through Bills for Laboratory Services
- Flow Cytometry (0537)

April 2019

- **Peripheral angioplasty**
—Percutaneous Revascularization of the Lower Extremities in Adults (0537)

March 2019

- **Perfusionist services**
—Facility Routine Services, Supplies and Equipment Reimbursement Policy (R12)
- **Ashkenazi Jewish laboratory panel**
—Genetic Testing Panels (R28)
—Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis (0514)

February 2019

- Diagnostic Microbe Testing for Sexually Transmitted Diseases (0530)
- National Correct Coding Initiatives for Facilities Reimbursement Policy (R09)

Information about these updates is available on the Cigna for Health Care Professionals website (CignaforHCP.com).



Coverage policy updates on CignaforHCP.com



Logout

Enter Keyword

SEARCH RESOURCES

BROWSE RESOURCES DOCUMENTS



Precertification

Learn how to properly request precertification for medical procedures, delegated ancillary vendors, and medications.



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Pharmacy Resources

Find information, drug lists and prior authorization forms.



Behavioral Health Resources

Review treatment guidelines for level of care determinations and clinical practice.



Behavioral Medical Management

Find the most relevant, up-to-date information on working together. This document is part of your contract.



Disability Resources

Get your questions answered and find the forms you need.



Reimbursement and Payment Policies

Find appeal policies, claim editing procedures, laboratory, and reimbursement



Coverage Policies

Know how to interpret our standard health coverage plan provisions.



Forms Center

Easily find the right form for the right purpose.



Reference Guides

Review reference guides to help make doing business with Cigna easier.



eCourses

Learn how Cigna tools can help make your job easier.



Drug List

Search for medications covered by Cigna plans.





Precertification changes

Precertification changes

Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes were added to and removed from the precertification list effective August and October 2019.

For more information

Visit CignaforHCP.com for an outline of monthly precertification updates and a complete list of services that require precertification for coverage.

See *Precertification Policies* under *Useful Links*.

resources

for you

- Quarterly *Network News*
- Use material in meeting packet
- Go to the Cigna for Health Care Professionals website (CignaforHCP.com)
- Contact:

Lindy Alexander, Experience Manager
Email: Lindy.Alexander@Cigna.com
Telephone: 479.846.0205



Email: NetworkNewsEditor@Cigna.com to be added to the distribution.

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QUESTIONS?

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