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WORKING WITH CIGNA

ARKANSAS MEDICAL SOCIETY
OCTOBER 2019

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Cigna®

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

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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.

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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**

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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

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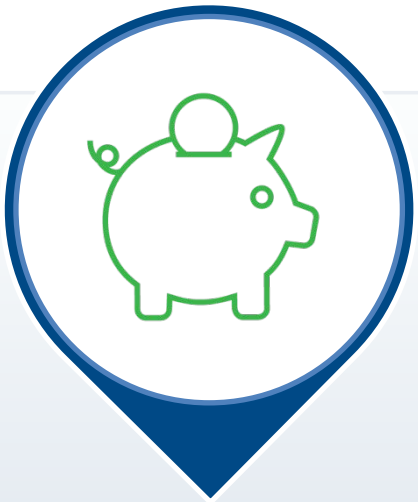
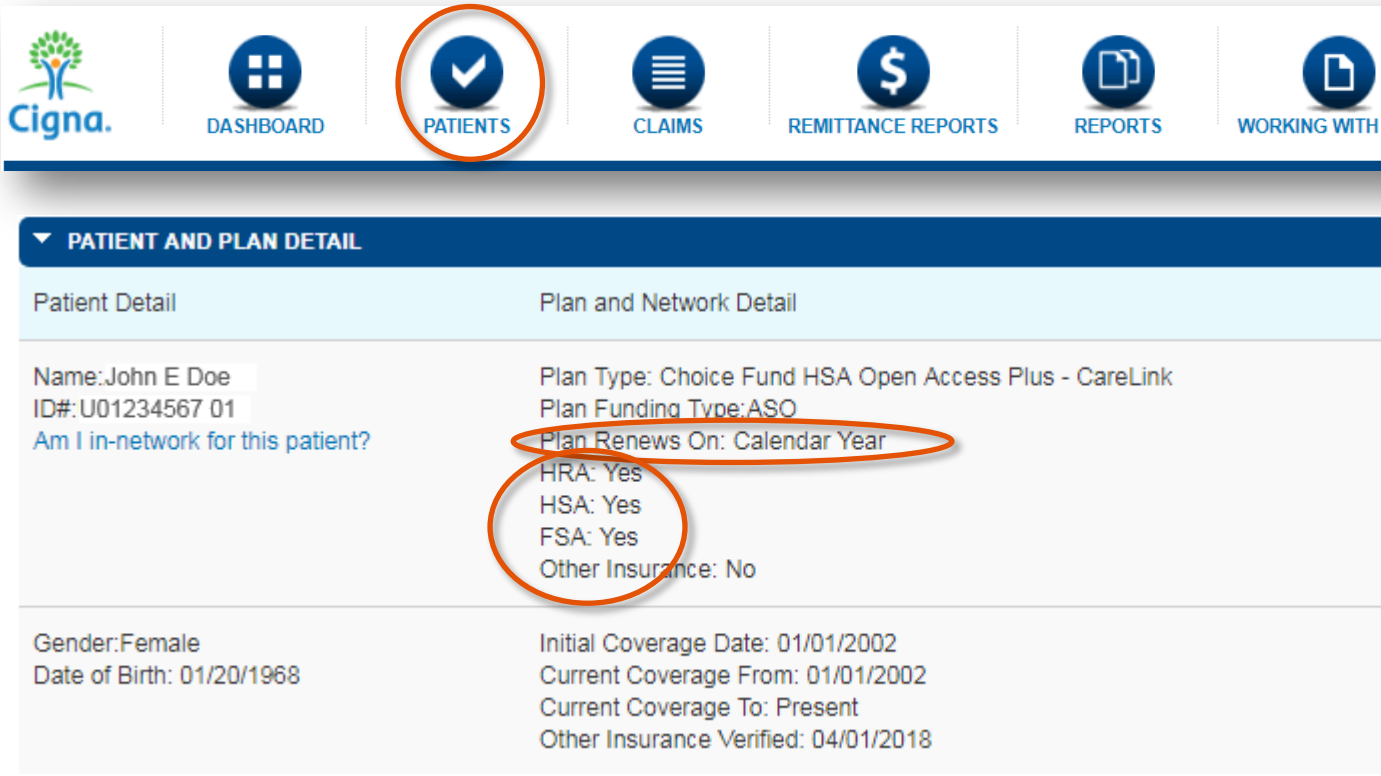
Patient and Plan Detail tab enhancements – plan renewal indicator and health account status



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.



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

Effective November 2017 & April 2018

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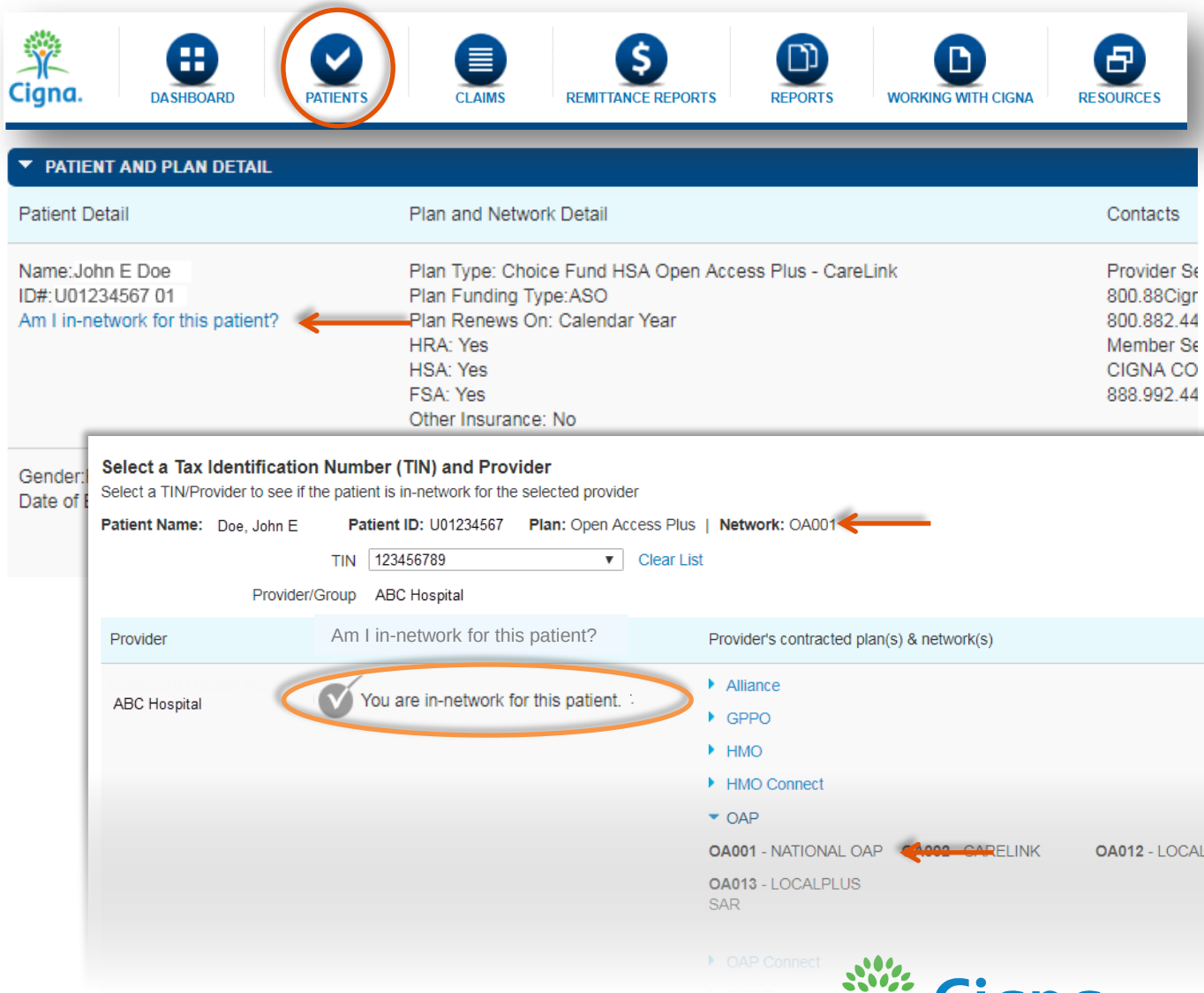
Patient and Plan Detail tab enhancements – network status

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.



Effective February 2018, updated July 2018

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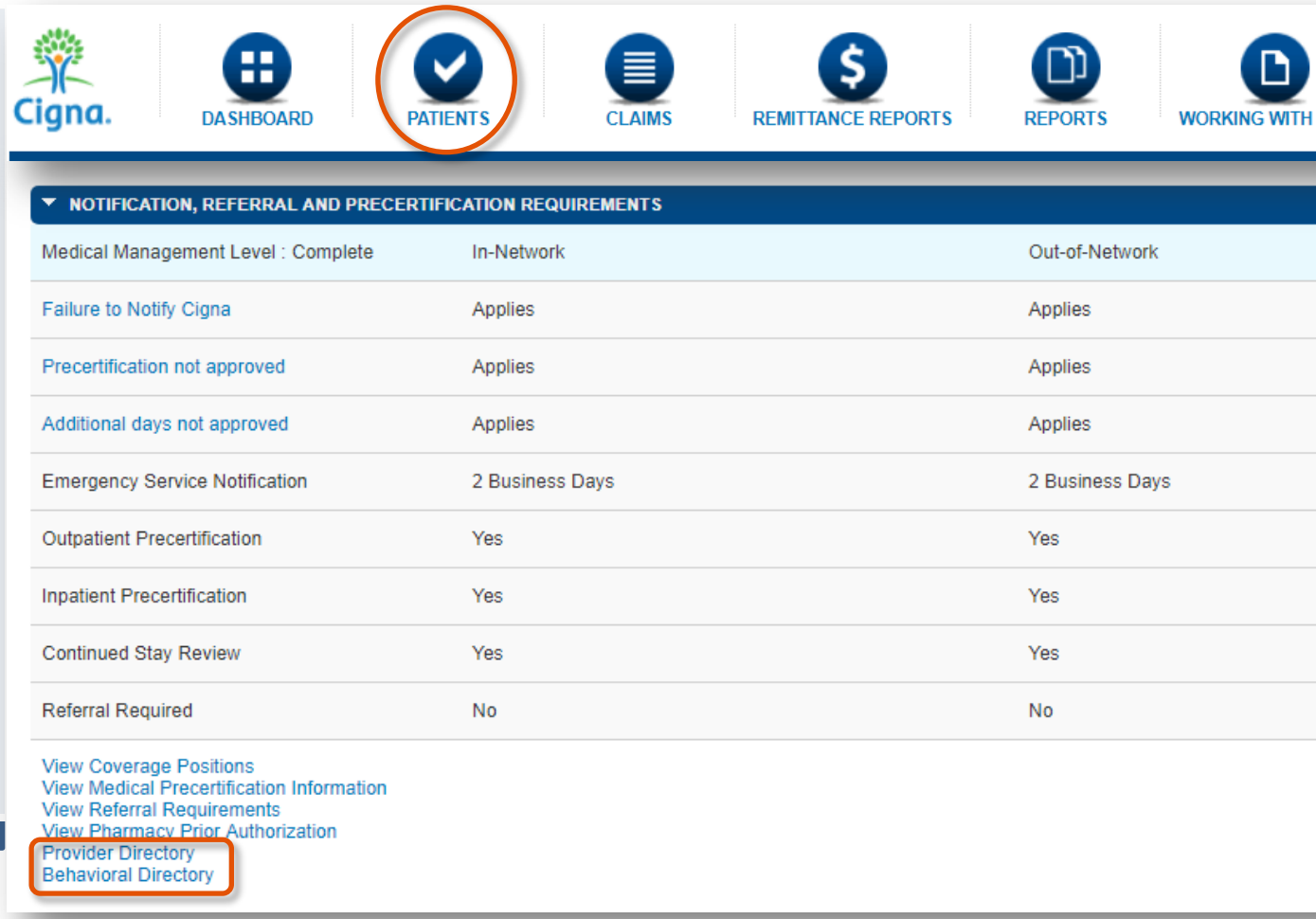
Notification, Referral, and Precertification Requirements tab enhancements – provider directory links

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.



Effective March 2018

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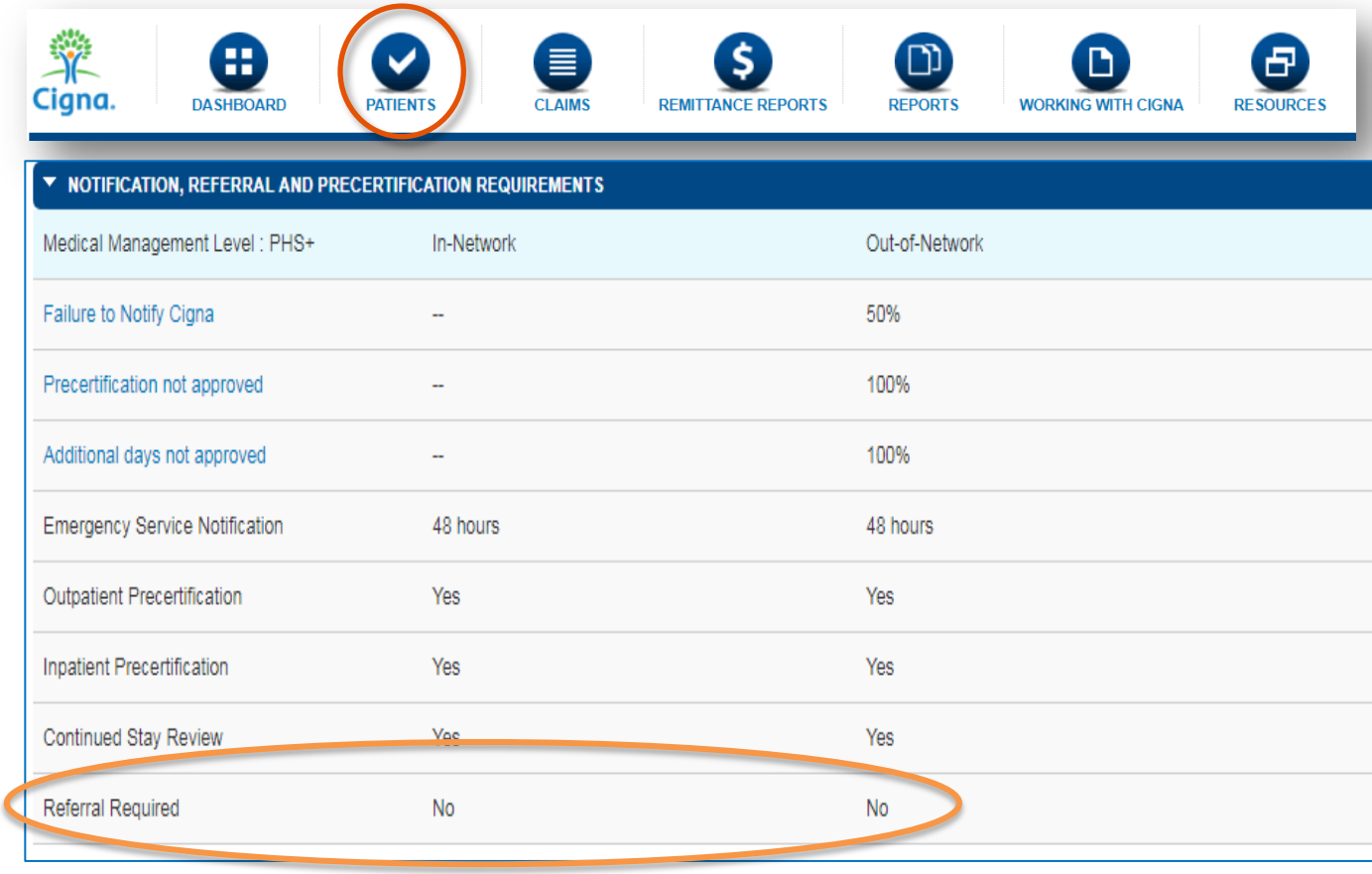
Notification, Referral, and Precertification Requirements tab enhancements – Referral Required indicator

Referral Required

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



Effective March 2018

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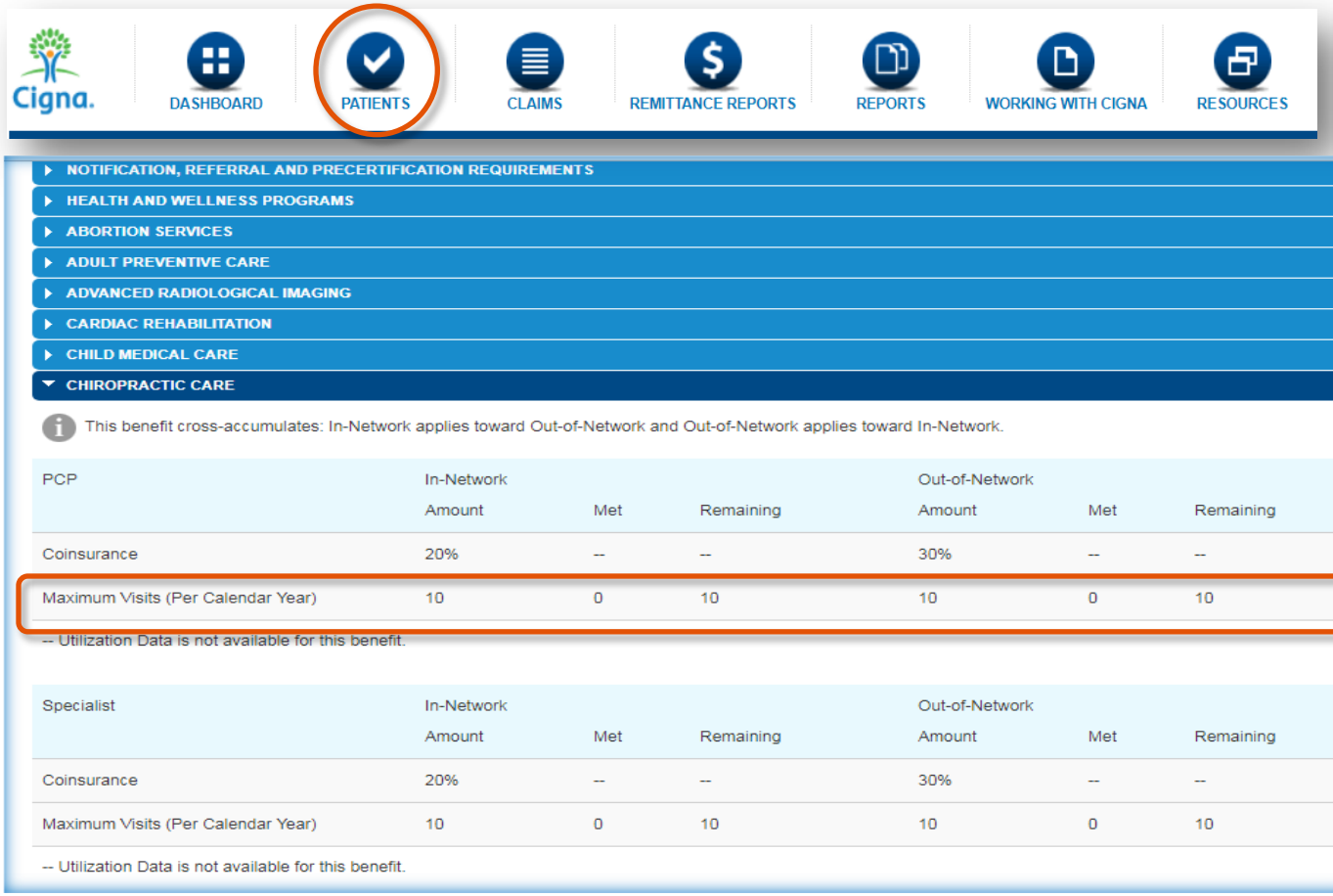
Frequency and utilization data

Frequency and utilization data

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



Effective May 2018

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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.

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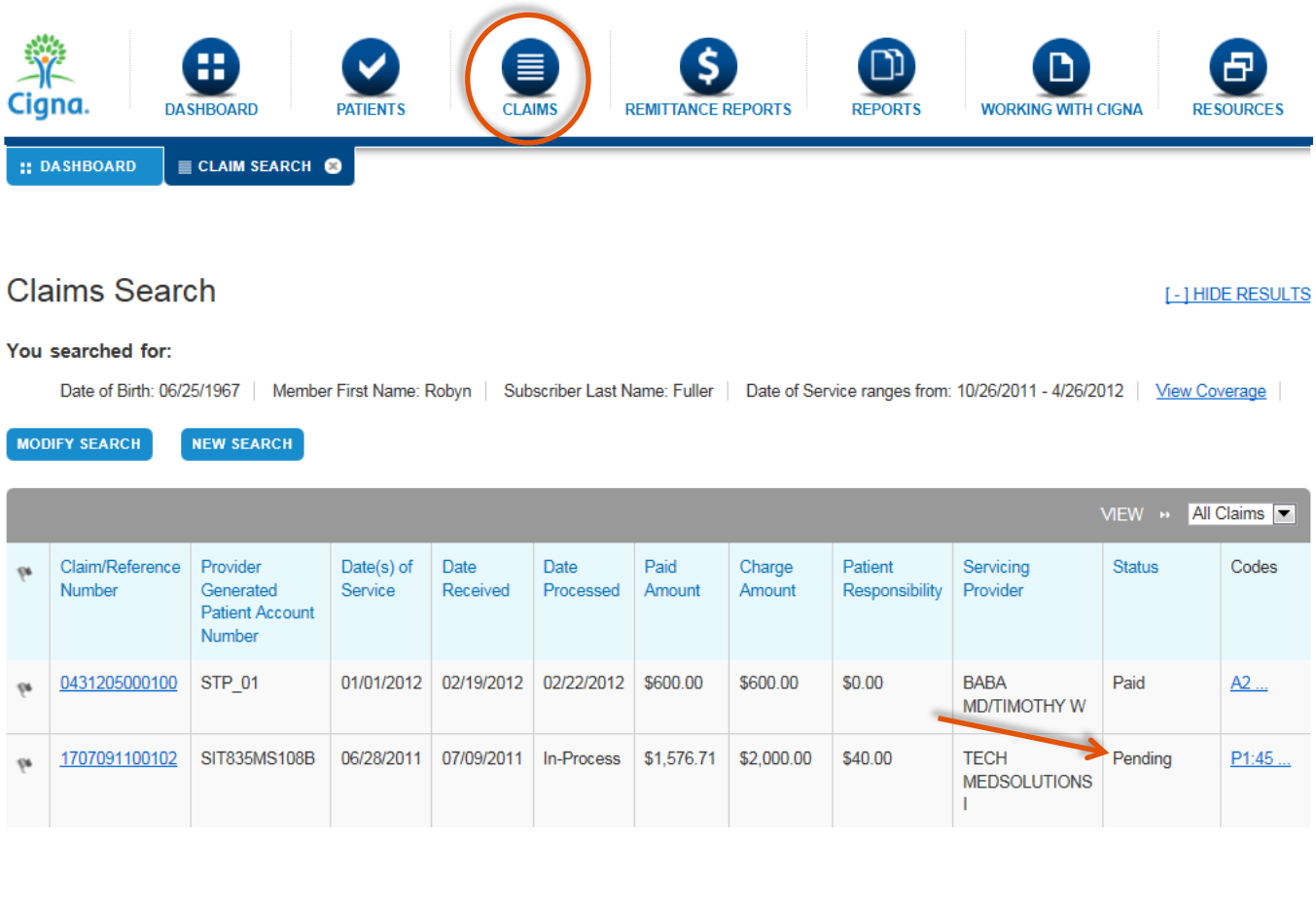
Claim Details screen enhancements

Pended claim attachments

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



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

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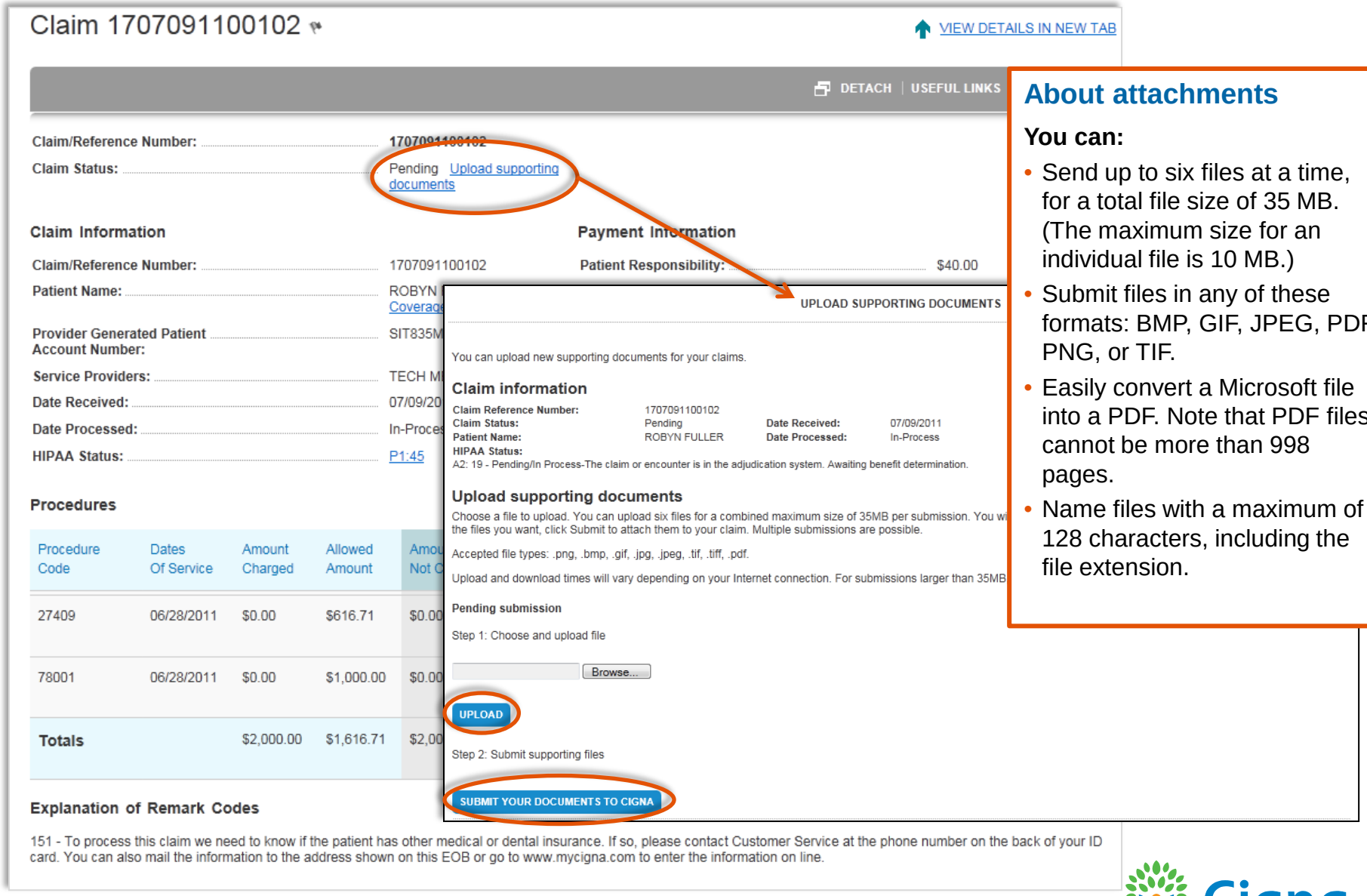
Pended claim attachments details



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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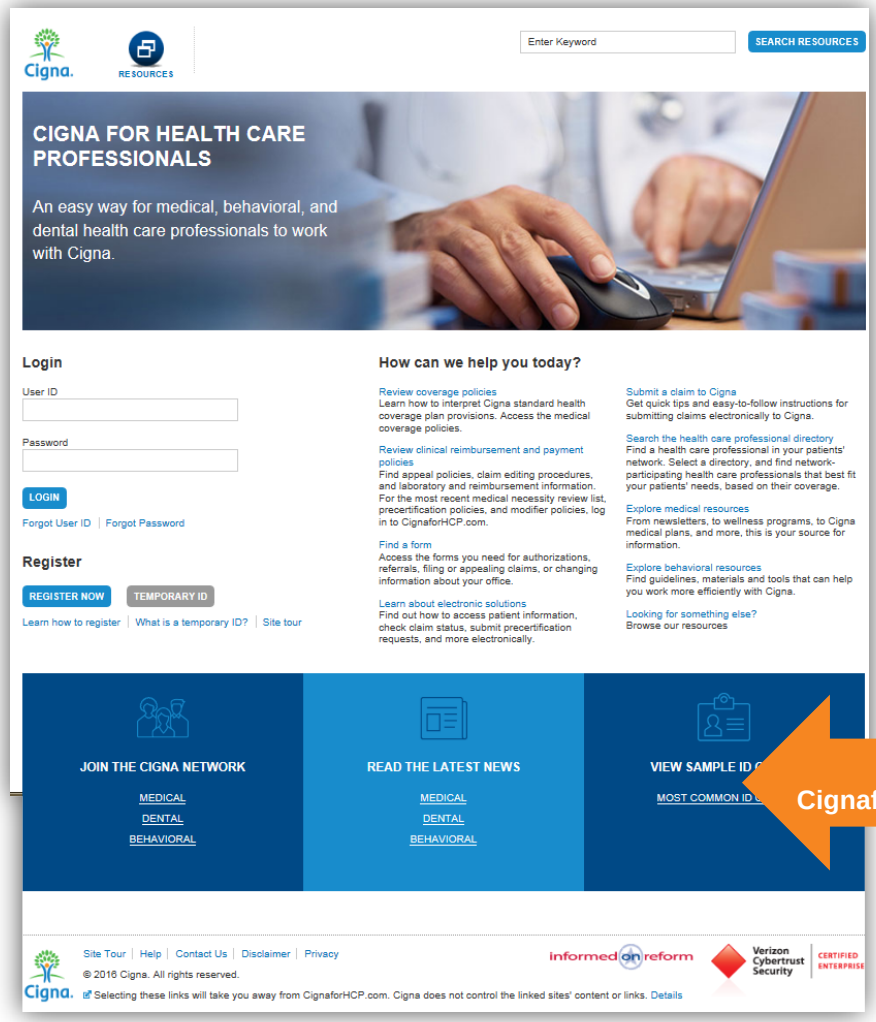
Accessing the digital ID card tool

On Cigna.com



On CignaforHCP.com

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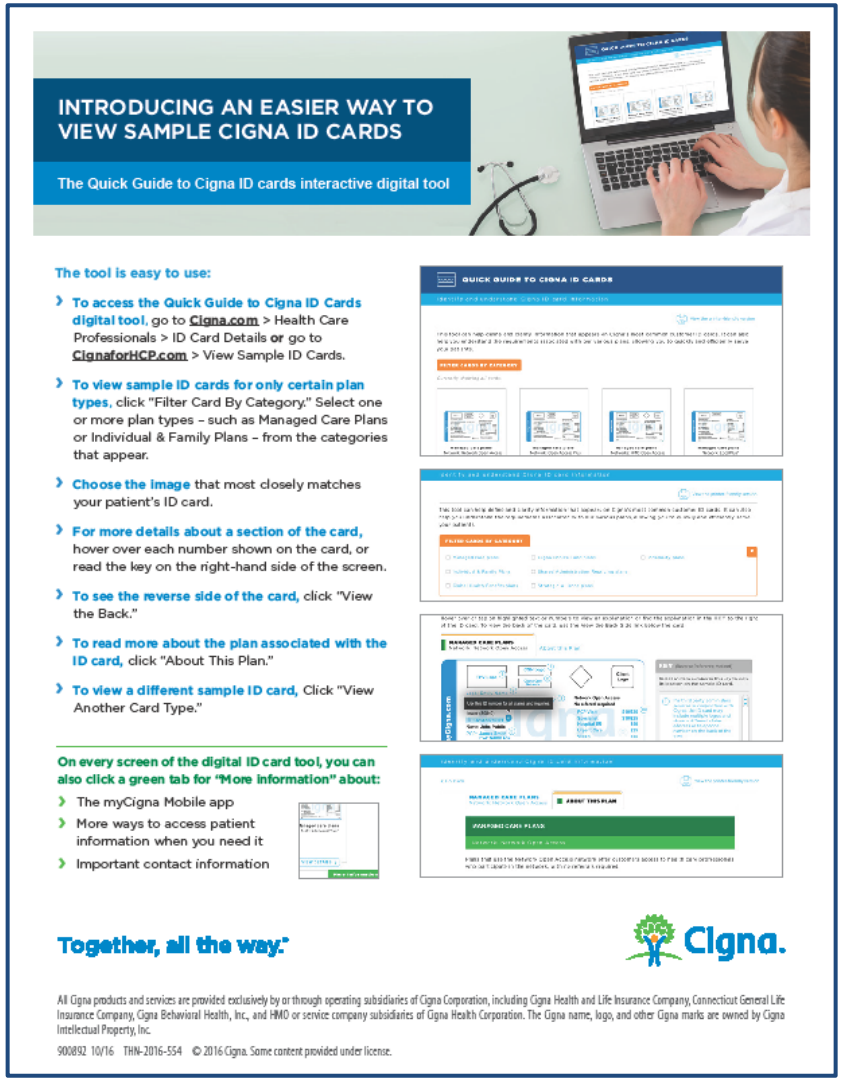
Using the digital ID card tool



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

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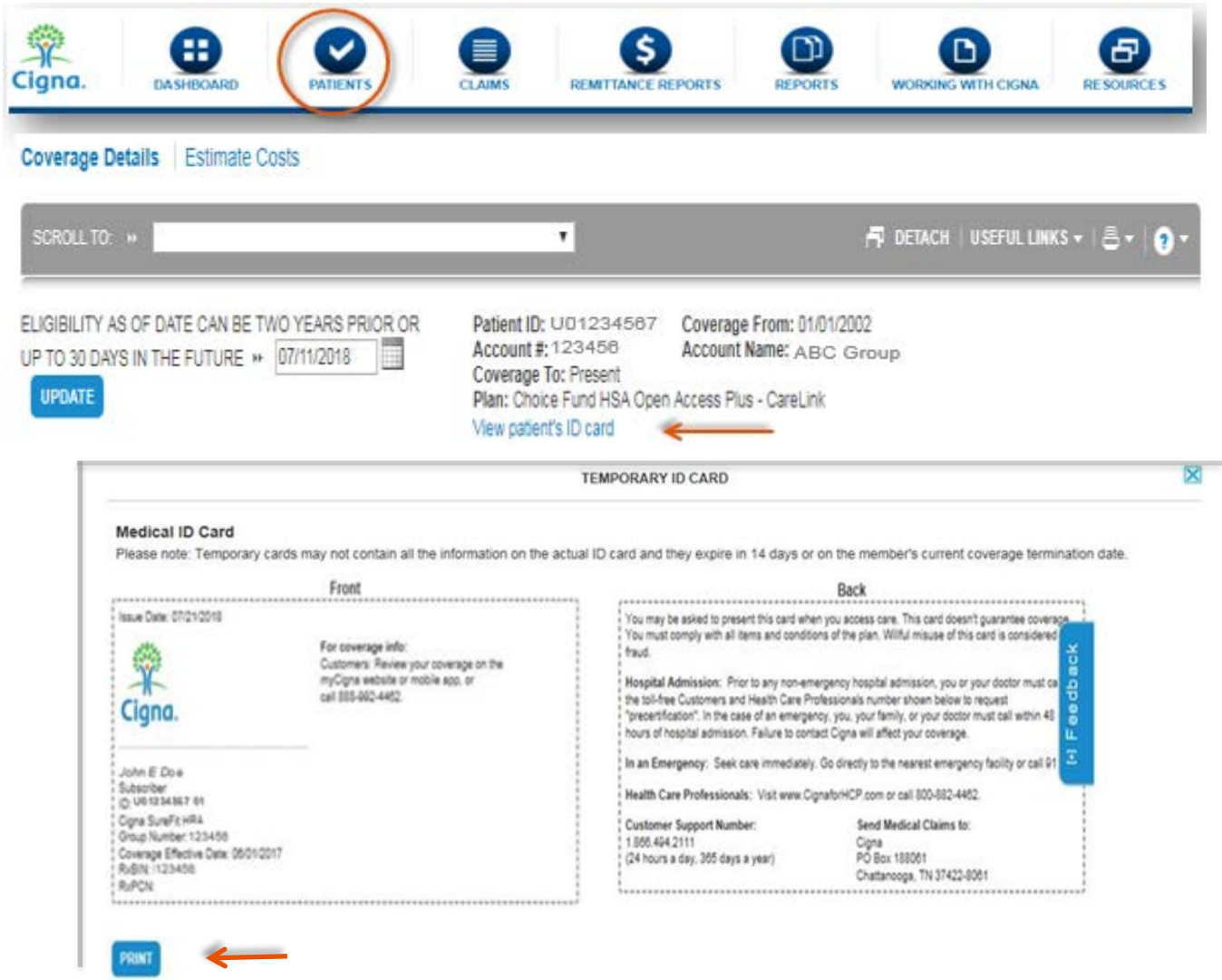
Patient digital ID card tool

View patient's ID card

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



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REAL TIME BENEFIT CHECK

Help patients avoid surprises at the pharmacy

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Current prescribing challenges

Patient

Sticker shock, treatment delays

Provider

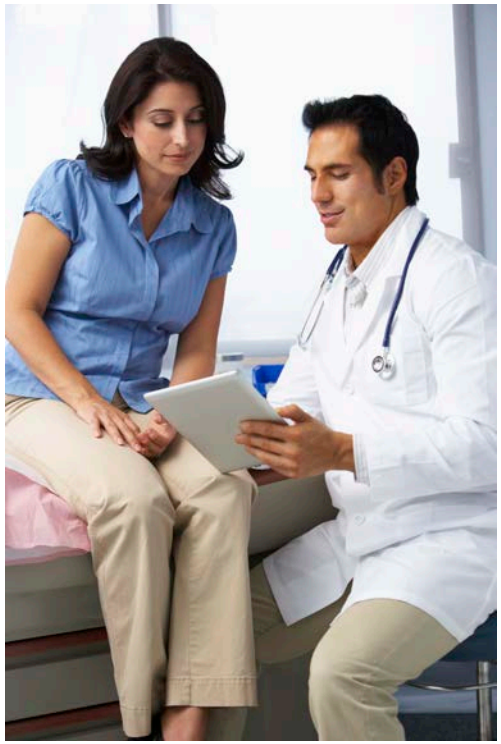
Lack of information, administrative burdens

Plan

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

Pharmacy

Abandoned prescriptions



Opportunities to reduce stakeholder

frustration and

unintended consequences

1.

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

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

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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.

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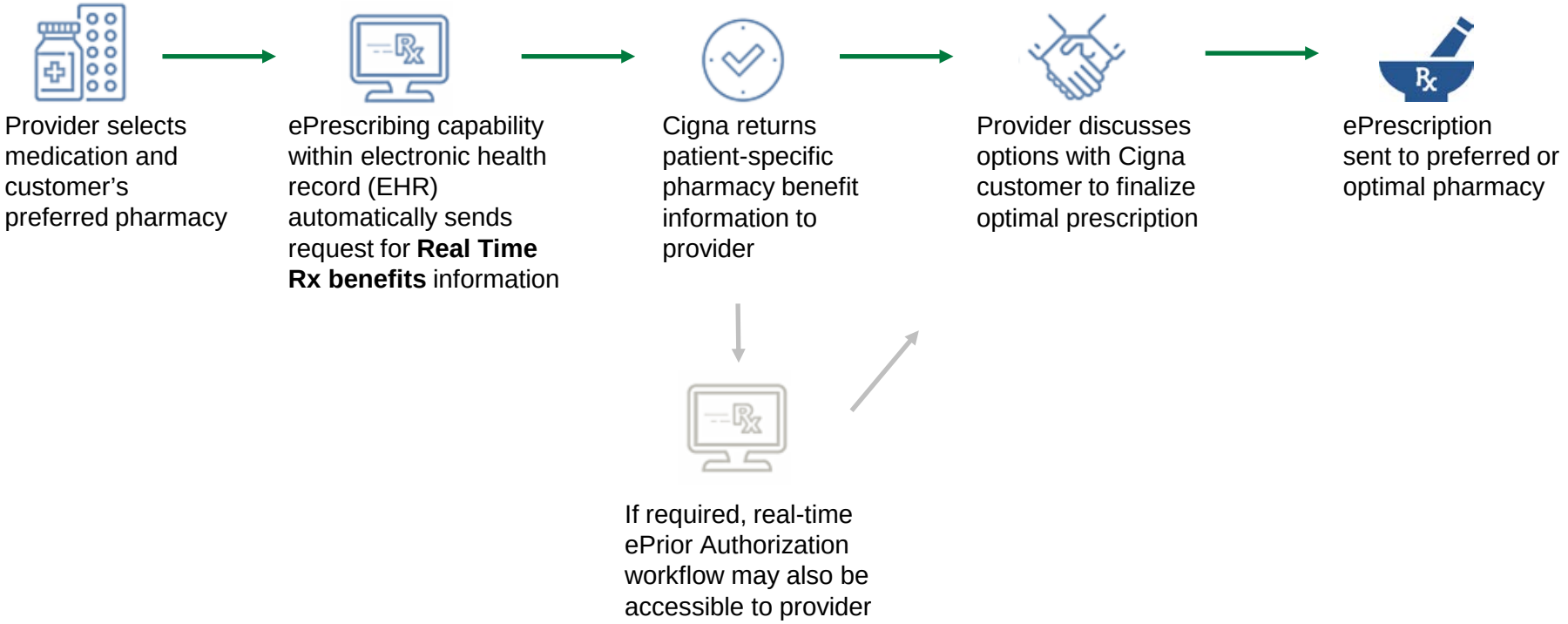
How RTBC works

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



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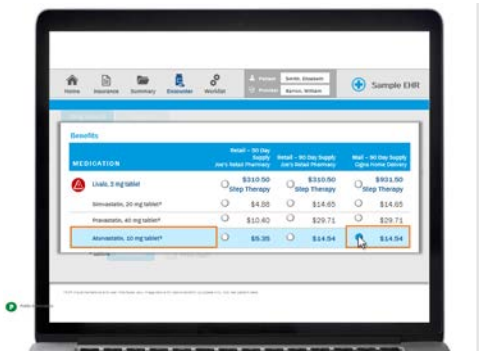
Key RTBC takeaways



- **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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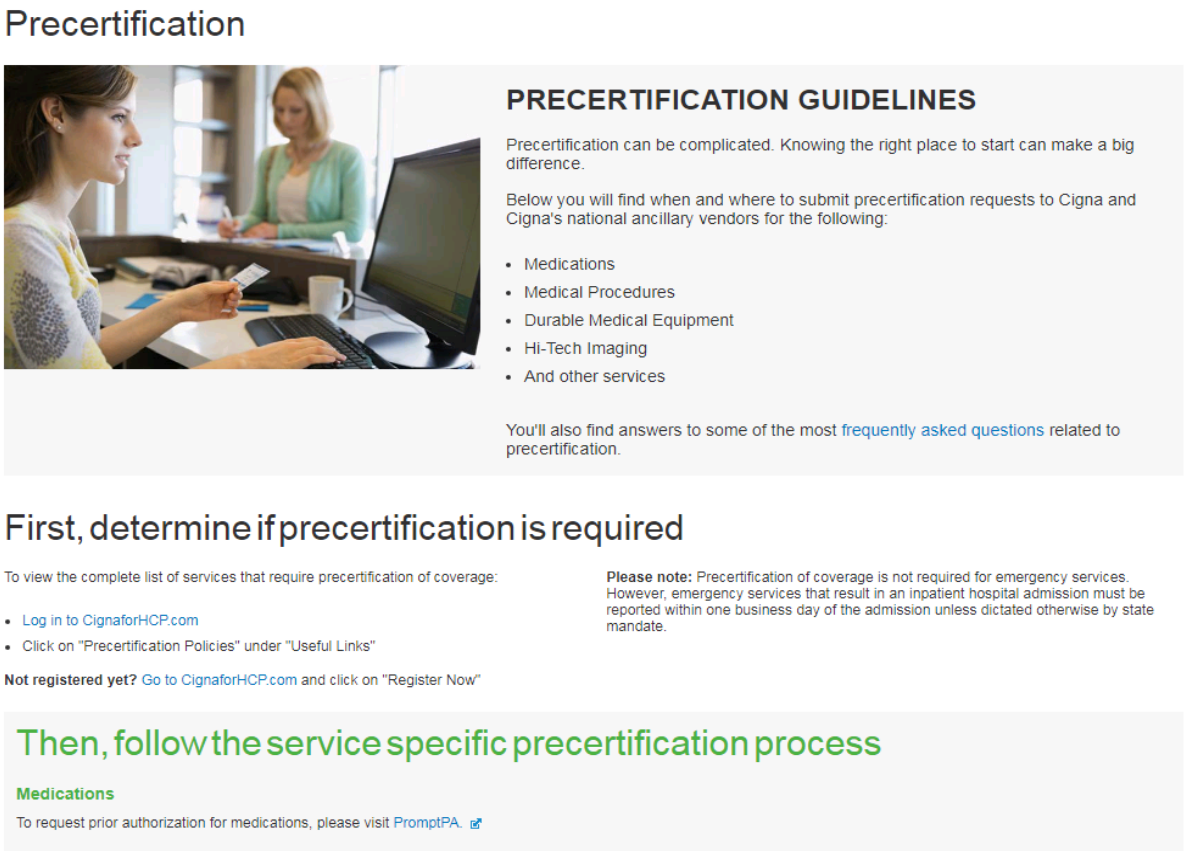
Precertification on CignaforHCP.com

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



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CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE

Method one

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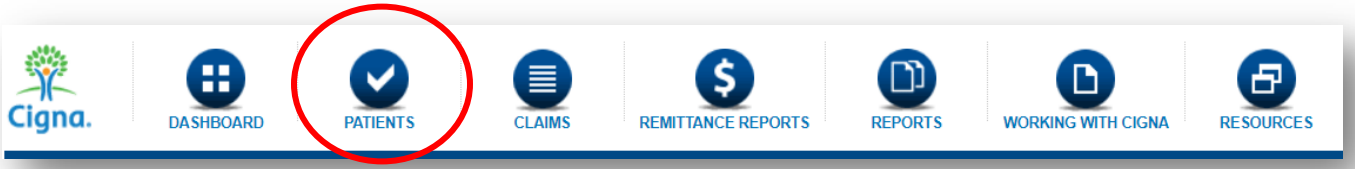
Cigna for Health Care Professionals website

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

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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

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Cigna for Health Care Professionals website

Master Outpatient Precertification List

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.

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

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	Intensive outpatient services-psychiatric	Added 08/27/2015

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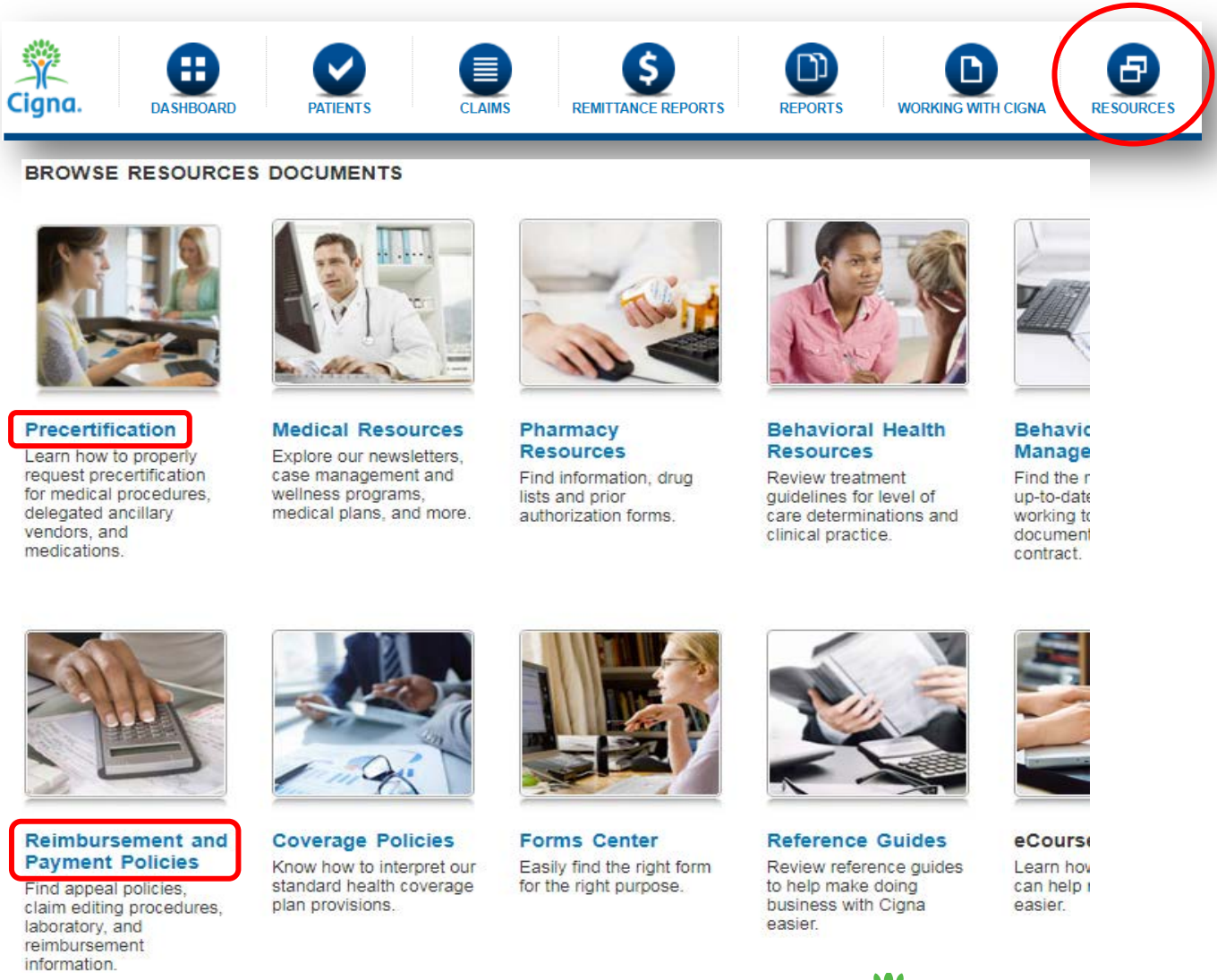
Cigna for Health Care Professionals website

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.



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ELECTRONIC DATA INTERCHANGE

Method 2

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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

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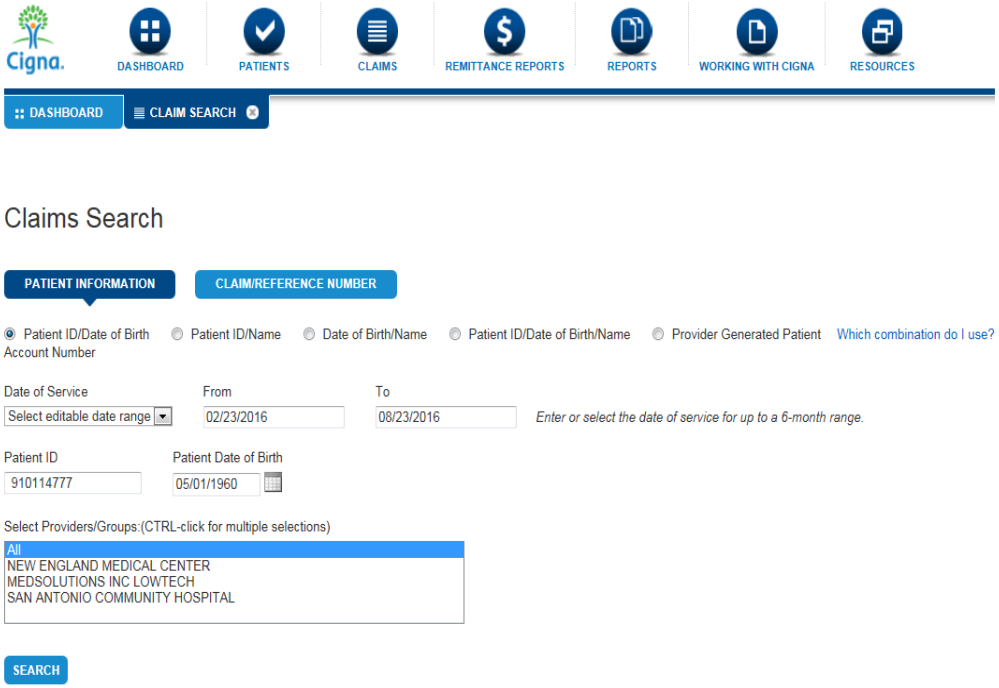
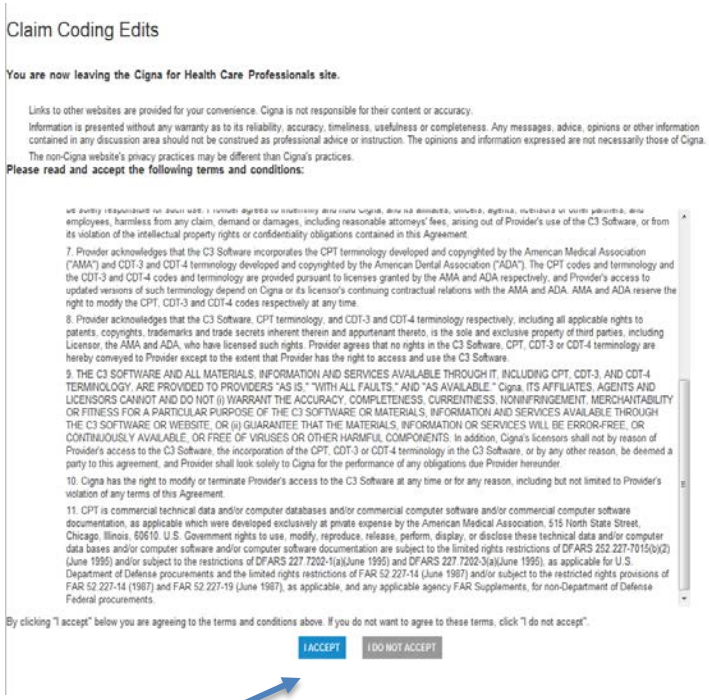
Clear Claim Connection™ (1 of 3)

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):





Click “I ACCEPT.”

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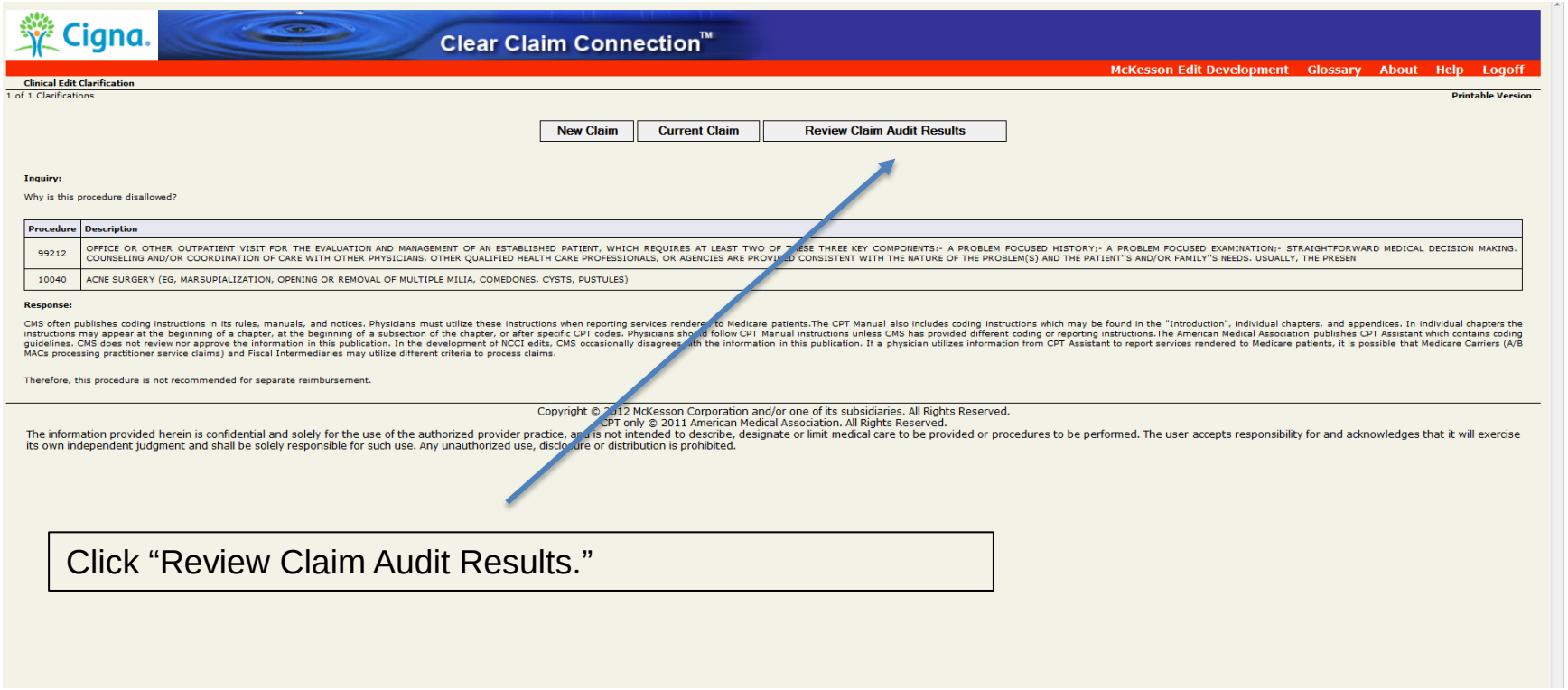
Clear Claim Connection (2 of 3)

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



Click "Review Claim Audit Results."

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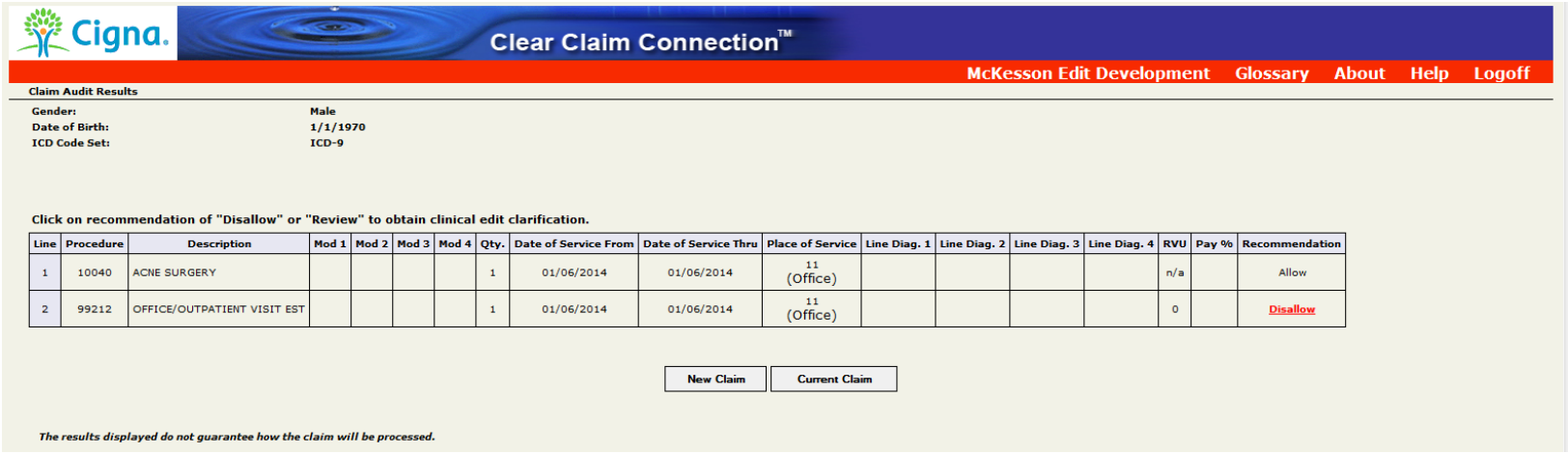
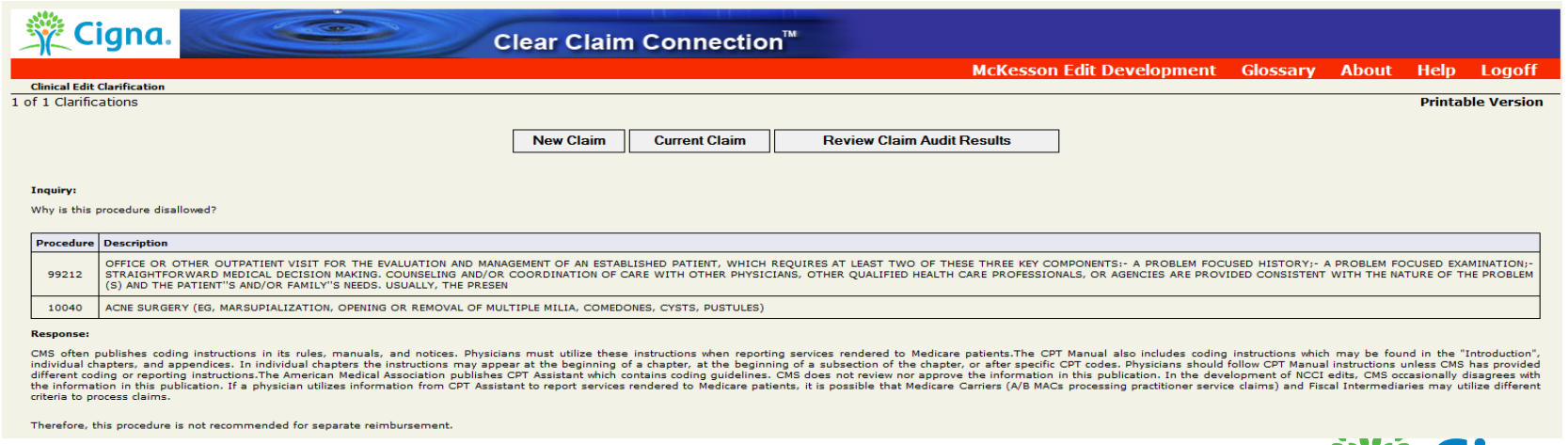
Clear Claim Connection (3 of 3)

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



The next screen provides a detailed explanation.



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CIGNAFORHCP.COM AND THIRD-PARTY ADMINISTRATORS

Payer Solutions and Shared Administration Accounts

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Identifying the type of account – payer solutions or shared administration

Patient search results

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

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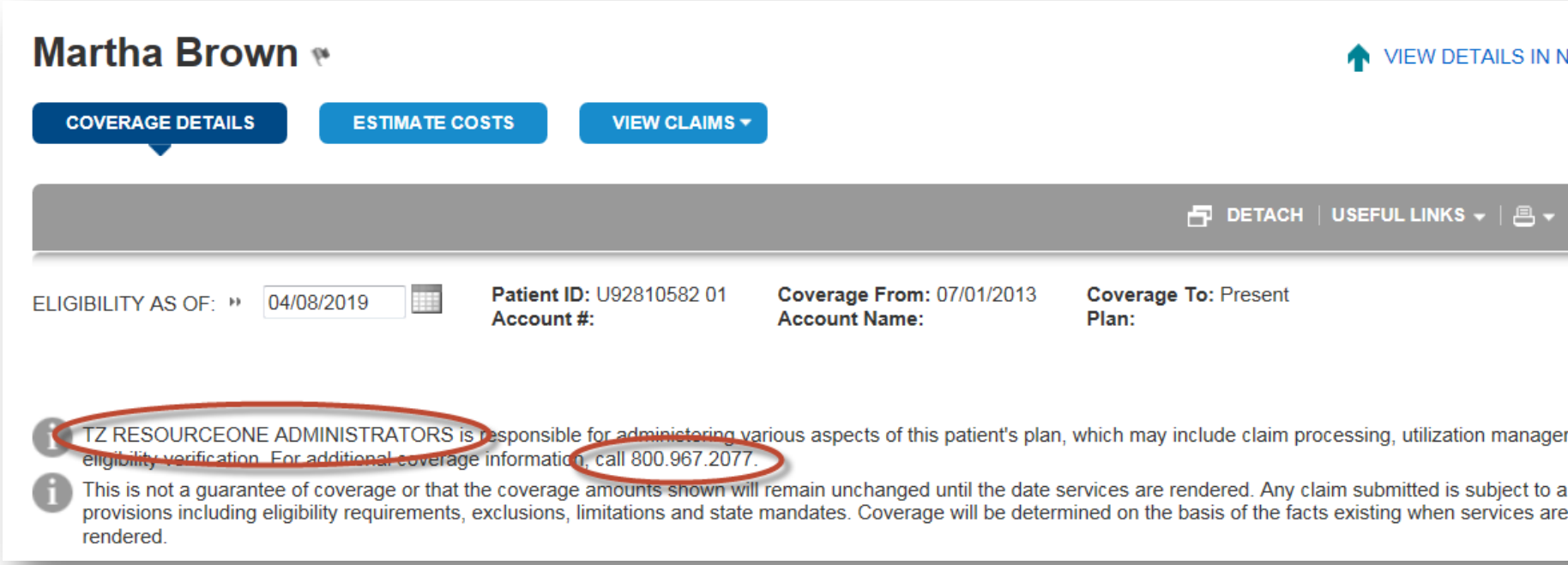
Identifying a patient with third-party administrator (TPA) coverage



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.

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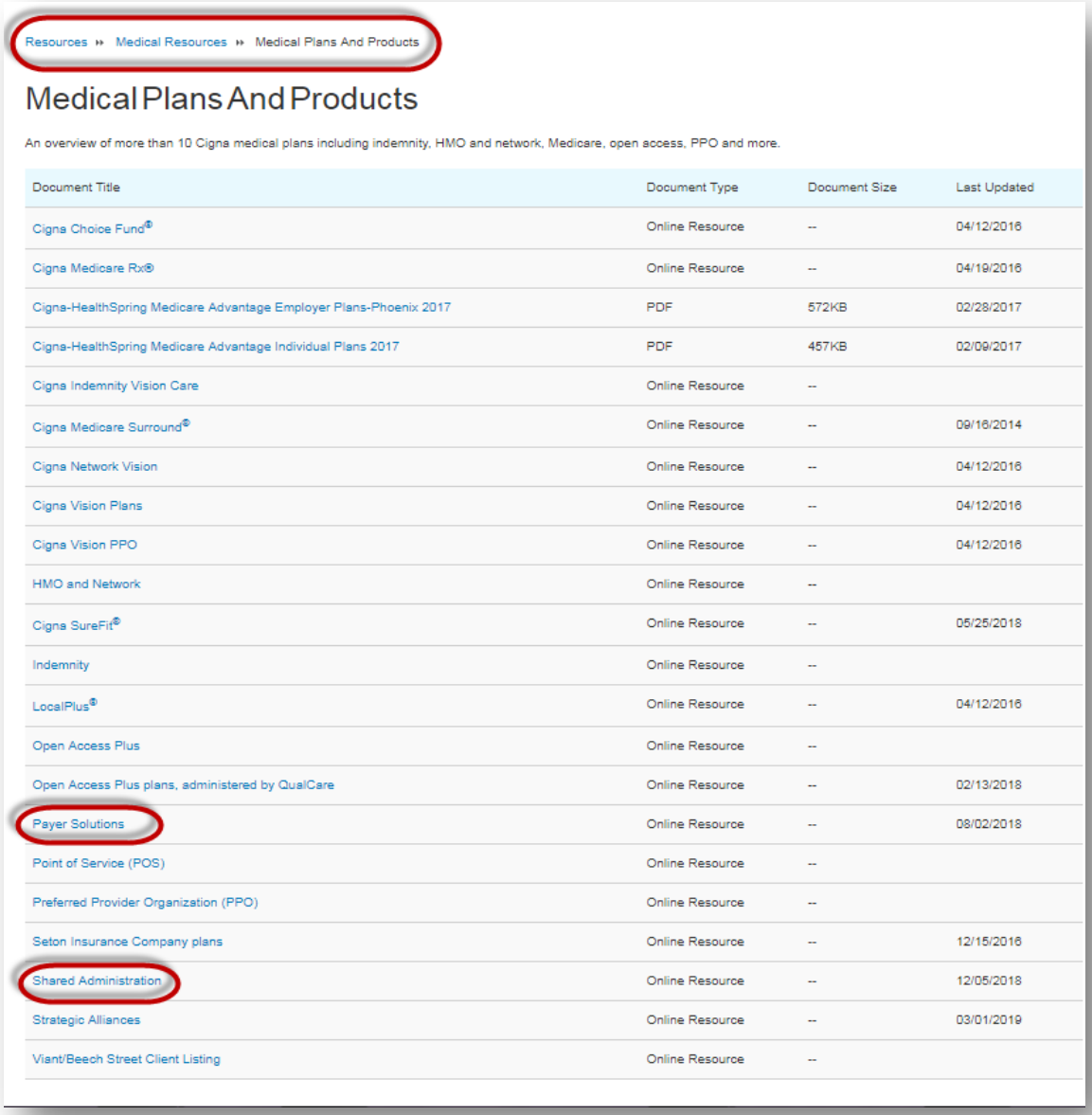
CignaforHCP.com > Resources > Medical Resources > Medical Plans and Products



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 -- Health care professional Taxpayer Identification Number (TIN)
  - Total amount billed -- Date of birth
  - Patient Cigna ID
- 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)

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Duplicate claim denials

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.

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Claim denial reasons

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.

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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.

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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

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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.

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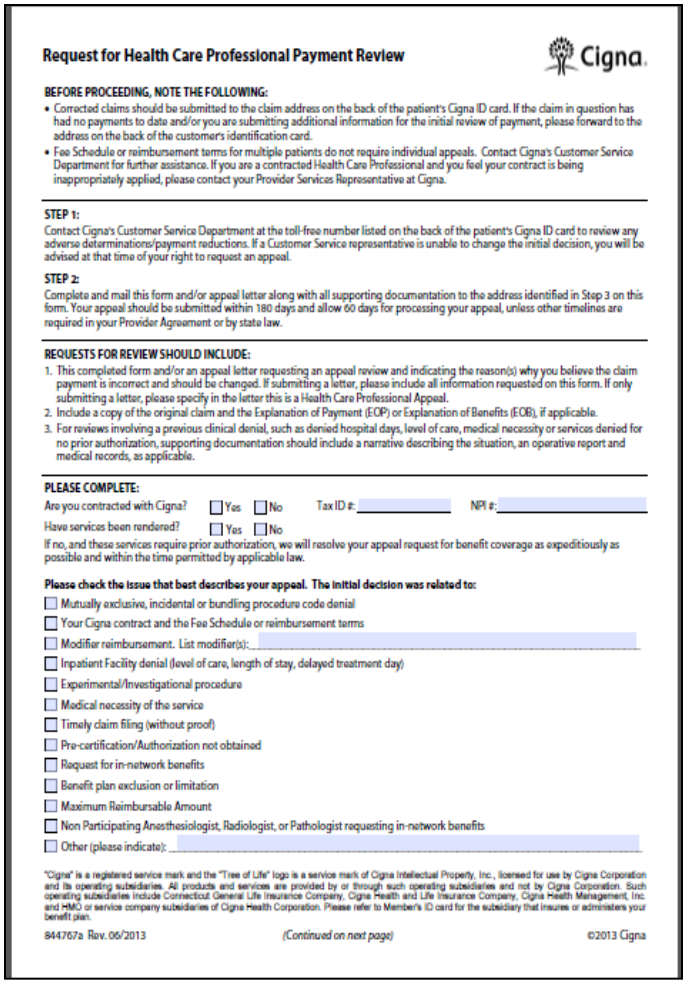
To file an appeal

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

Cigna

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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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).

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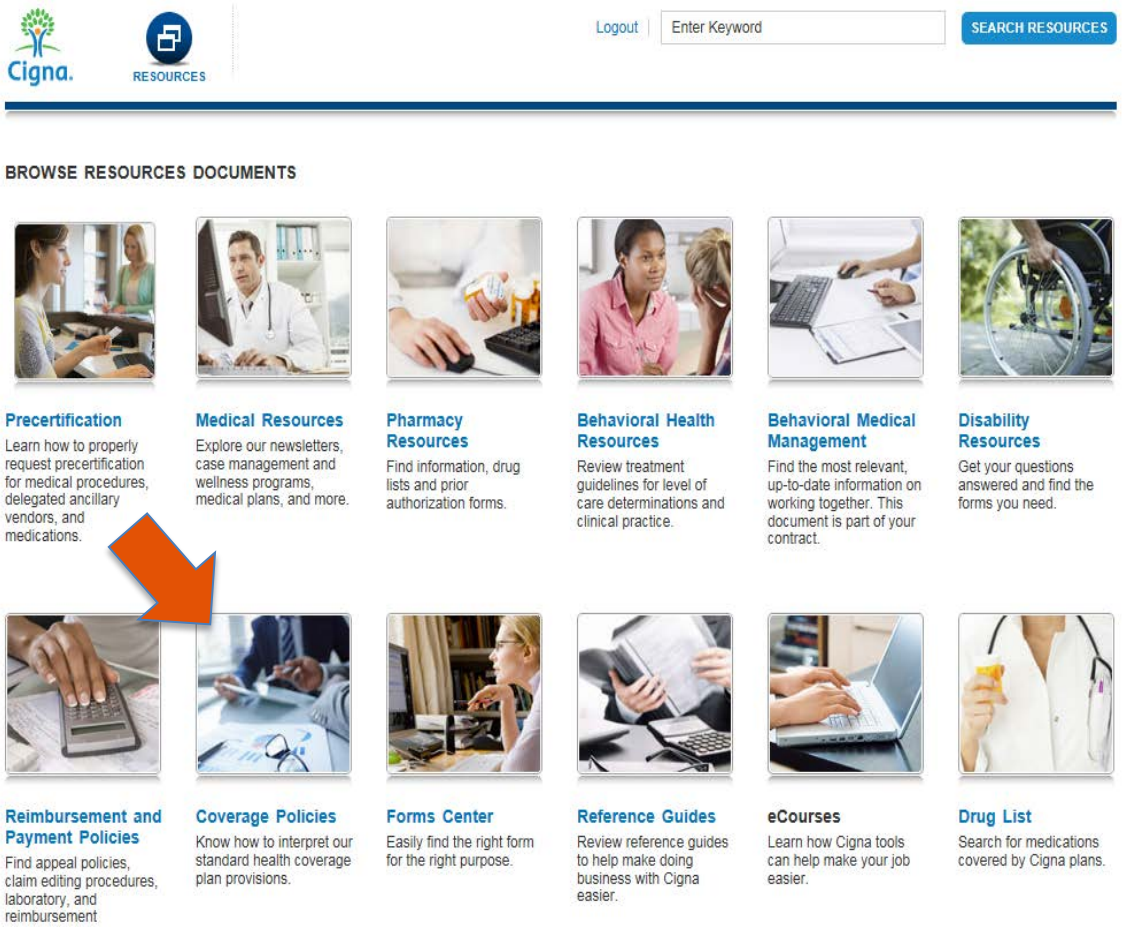
Coverage policy updates on CignaforHCP.com



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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*.

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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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