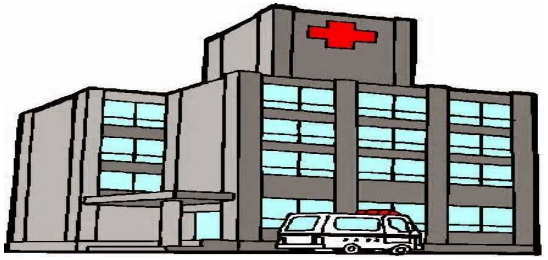
THFMA Annual Payer Summit
March 2016

CIGNA-HEALTHSPRING

Cigna-HealthSpring

Cigna-HealthSpring is one of the leading health plans in the United States focused on caring for the senior population, predominately through Medicare Advantage and other Medicare and Medicaid products. Our concentration on this market has allowed us to develop a unique approach to healthcare coverage for beneficiaries.

Institutional Network Operations Team



Management

Mary Beth Liebhart - Manager, Network Operations-
marybeth.liebhart@healthspring.com

West TN Team

Suzette Stevens – Network Administrator, West Tennessee Region-
suzette.stevens@healthspring.com

Middle & East TN Teams

Jennifer Douglas – Network Administrator, Middle Tennessee Region
jennifer.douglas@healthspring.com

Lybronda Middlebrooks – Network Administrator, Middle & East Tennessee Region
lybronda.middlebrooks@healthspring.com

Terri Ward – Network Administrator, Middle & East Tennessee Region
terri.ward@healthspring.com

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Network Administrators Role:

- Contract negotiation and management
  - Current service area
  - Expansion service area

- Facilitate educational meetings with provider
  - On-site or webinar
  - Policy and procedure review
- Cigna-HealthSpring provider liaison
  - Issue resolution and troubleshooting
  - Claims, credentialing, health services, appeals, etc.

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How to reach us……

530 Great Circle Road
Nashville, TN 37228
Toll Free: (800) 230-6138
Local: (615) 291-7039
Fax: (615) 291-7547
Web: www.cignahealthspring.com




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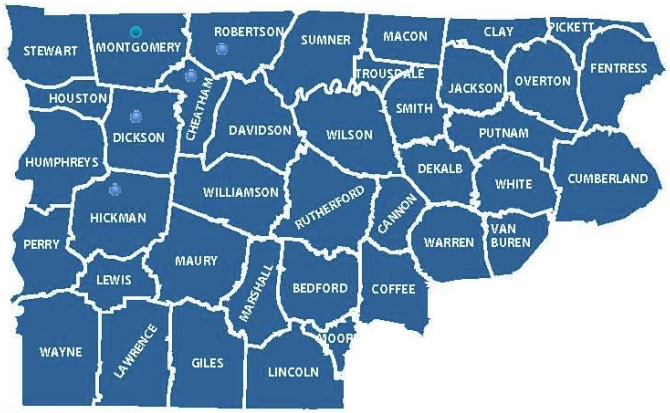
Tennessee, Arkansas, and North Georgia

2016 Medicare Advantage Service Area Counties

Tennessee

West TN with AR

TN counties: Benton, Carroll, Chester, Crockett, Decatur, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Lauderdale, Madison, McNairy, Shelby, and Tipton
Arkansas county: Craighead, Crittenden, Greene, Lawrence, Poinsett, and Mississippi



Middle TN

TN counties: Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson

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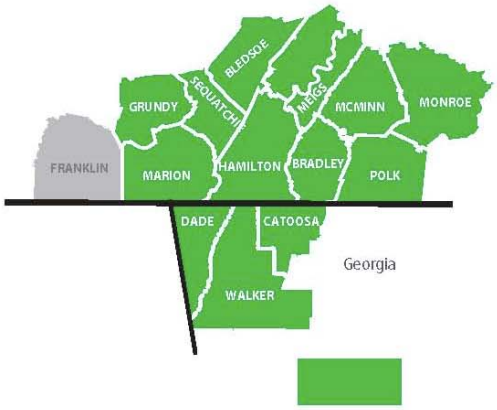
Cigna-HealthSpring
Tennessee, Arkansas, and North Georgia
2016 Medicare Advantage Service Area Counties

Knoxville

TN counties: Anderson, Blount, Campbell, Cocke, Grainger, Hamblen, Hancock, Jefferson, Knox, Loudon, Morgan, Roane, Scott, Sevier, and Union



Chattanooga with North GA

TN counties: Bledsoe, Bradley, Grundy, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea, and Sequatchie
North GA Counties: Catoosa, Dade, and Walker

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STARS

STAR RATING

Cigna-HealthSpring of Tennessee is a 4.5 STAR Plan, scoring in the top 20% of plans nationally.

CMS evaluates the overall quality of MA plans through the STAR rating program.

The program aligns with our corporate vision by supporting continuous quality improvement and care coordination for our members.

Plans receive an overall rating based on performance in the following categories:

- Members' compliance with preventative care and screening recommendations
- Chronic condition management
- Plan responsiveness, access to care, and overall quality
- Customer service complaints and appeals
- Clarity and accuracy of prescription drug information and pricing

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CMS STAR PROGRAM OVERVIEW

2007

- First STAR ratings were published

PURPOSE

- Help enrollees make informed enrolment decisions
- Provides overall indication of quality of a plan

2010

- Affordable Care Act mandated MA plans be paid according to level of quality provided

REVENUE IMPLICATIONS

- It was determined that only 4 and 5 STAR plans would receive a “quality bonus”
- Bonus is actually a revenue withhold. Plans can earn back 5% of revenue if 4 or 5 STAR rating is achieved

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Provider Requirement - HL7-Encounter Data Submissions

- Due to Centers for Medicare and Medicaid Services (CMS) regulations, Cigna-HealthSpring has implemented front-end validation edits in accordance with the CMS implementation guide on all Electronic Data Interchange (EDI) transactions submitted to ensure all claims, lab results, eligibility and encounter data are compliant.

- Cigna-HealthSpring uses an edit tool to identify claims, lab results, eligibility and encounter data submitted that is not in accordance with the CMS implementation file. Incorrect formatting results in a rejection of the file in its entirety. In addition, a field record validation occurs and may result in a rejection. If a clearinghouse submits electronic data on behalf of the provider; all file acknowledgements will be communicated back to the clearinghouse. The submitter will receive a TA1 acknowledgement confirming receipt of the submitted data file. The submitter will also receive a 999 acknowledgement. The 999 acknowledgment includes additional information about whether the received transaction had errors. This includes whether the transaction is in compliance with HIPAA requirements.

  The 999 Acknowledgement may produce three results:
  - Accepted (A)
  - Rejected (R)
  - Accepted with errors (E)

- Additional information on HIPAA X12 format and EDI transactions can be found online at: www.cms.gov

- Cigna-HealthSpring is dedicated to making the use of HIPAA X12 format for EDI transactions as seamless as possible. If you have any questions regarding the required format or the EDI process, please contact the Cigna-HealthSpring Information Technology Help Desk at 1-866-780-8553. You may also visit the Cigna-HealthSpring website for schedule and additional details at www.cigna-healthspring.com.

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Member Eligibility

Membership Card

Cigna HealthSpring

MedicareRx
Prescription Drug Coverage

<Plan Name>

ID: <Member ID>
Name: <Member Name>
PCP: <Provider Name>
Phone: <Provider Phone Number>
Network: <Network Name>
RxBIN: 017010
RxPCN: CIHSCARE
<contract & PBP>

Copays
PCP: <copay>
Specialist: <copay>
ER: <copay>
Urgent Care: <copay>

SAMPLE

This card does not guarantee coverage or payment.

<Barcode>

<Services may require a referral by the PCP or authorization by the Health Plan.>
<Medicare limiting charges apply.>

Customer Service: <phone number> TTY: <phone number>
Provider Services: <phone number>
Authorization/Referral: <phone number>
Medical Claims: <address>

Pharmacy Help Desk: <Phone number>
Pharmacy Claims: <address>

24-Hour Nurse Line: <phone number>

Website: <URL>

SAMPLE

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When Verifying Member Eligibility Ensure the Following:

- **Member:**
  - Active with Cigna-HealthSpring on date(s) of service
  - Co-Pay and Co-insurance responsibility and out-of-pocket (OOP) (based on claims processed at time of verification)
  - Services are covered benefits per member benefit plan
- **Provider:**
  - In-network with the Member's plan → if you are told you are out-of-network, please contact your Institutional Network Administrator before seeing the Member.
  - Member's **PCP/Specialist,** if applicable → does it match the information you have on file?
- ***Note***: The "Network ID" on the membership card denotes the specific IPA/POD that a Member 's PCP is affiliated. Members will have the same network as their PCP. Please make sure you have verified network access/referral process as each IPA/POD may have different requirements.

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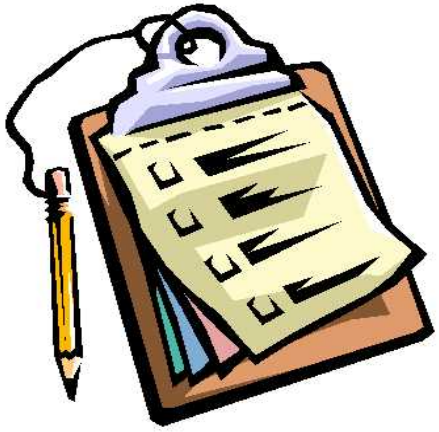
Where to Verify Member Eligibility

1.) Members Identification Card

2.) HealthSpring Connect – Cigna-HealthSpring's "free" on-line resource tool.

3.) Provider Services

- **Medical :** (800) 230-6138
- **Behavioral Health** : (800) 453-4464



Provider Services phone hours are 8:00am -5:00pm CST

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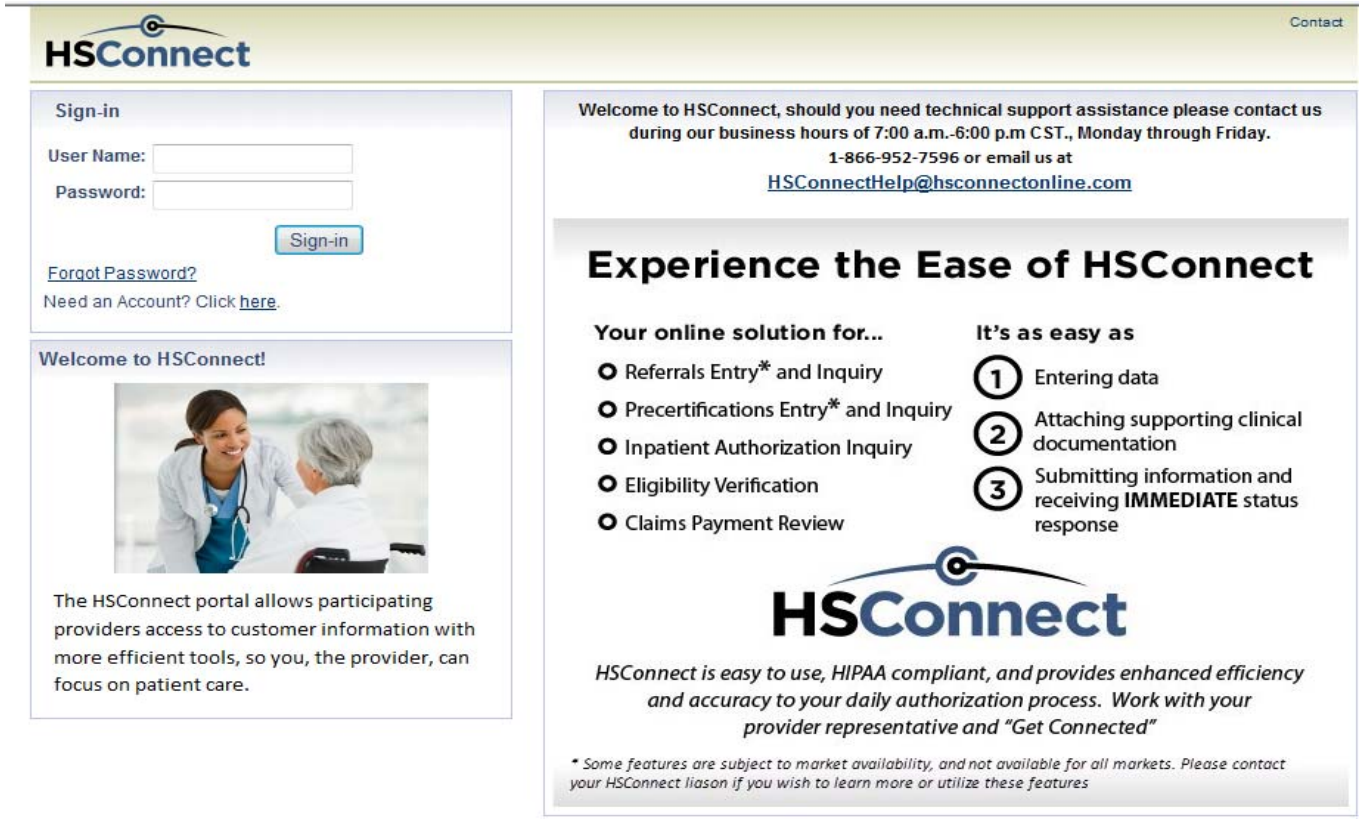
HealthSpring Connect

Your online solution for referral entry and inquiry, inpatient authorization inquiry, eligibility verification, and claims payment review.

https://healthspring.hsconnectonline.com/HSConnect



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Out-of-Pocket Maximum

- Once the Member reaches **$6,700.00*** of out of pocket expenses (i.e., co-pays, co-insurance), the Member no longer has a cost share for those services included in the OOP max. Cigna-HealthSpring pays 100%.
- Services included in the out of pocket max: ambulance transports, dialysis, DME, home healthcare, hospital admissions, Infusion care, O&P, outpatient surgery, SNF stays, outpatient therapy visits, outpatient diagnostic tests
- Supplemental benefits are the only exclusion to the out of pocket max.
- Call **Provider Services** to verify how much of the out of pocket max has been met. Note all out of pocket information is based on processed claims as of the time that you inquire.

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Health Services

CIGNA-HealthSpring: More from Medicare

We focus on Patient Outcomes & Quality through physician engagement and interaction:

- **Partnership for Quality** (P4Q): *Promotes preventive screenings and chronic care management to improve patients' health outcomes and quality of life*
- **Independent Physician Associations** (IPA/IPODS): *Promotes collaboration between PCPs and specialists in the care of each patient*
- **Provider Tools** (HSConnect, CareBridge): *Facilitates communication between HealthSpring and our provider network*
- **Wellness & Prevention Initiatives** (360 Exams, Health Maintenance Reports): *Promotes preventive care and monitors the chronic conditions of our members*
- **Patient Programs** (Community Based Case Management, Care Transition Coordination): *Follows patient care beyond the physician office to ensure the highest level of patient compliance*

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Chronic Care Programs

- **Virtual CHF Program-**Home based monitoring and educational program for patients with a diagnosis of CHF during and inpatient hospitalization. Program combines an educational curriculum, motivational message, and monitoring equipment.(bp, pulse, weight)

- **CROM Program-**Partnership that provides in home respiratory services to our members.

- **Aspire Health-**Home based palliative care for people with advanced disease and chronic illnesses. Anticipated to have life expectancy of 1 yr. or less. Co-management with the PCP.

- **Alegis-**Independent practitioner program in home, separate from PCP, which assesses and delivers care to members that have conditions/needs not easily met by the normal PCP model.

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Prior Authorization

- Cigna-HealthSpring Acute Care Case Managers (ACCM) are assigned on-site or telephonically to each participating facility.
- The ACCM works with the facility to provide the authorization, in addition to providing SNF authorizations at the time of discharge, as needed.
- In order to process a request for authorization the following information is needed:
  - Member name and Cigna-HealthSpring ID#
  - Name of ordering physician and physician order
  - CPT/Revenue/Per Diem code(s) & ICD-9 code(s)
  - Recent office visit notes
  - Clinical documentation that supports the request (VERY IMPORTANT!)
  - CMN, if applicable
  - Requests missing this information may be delayed or returned for additional information.

Outpatient Prior Authorization

TRIAGE UNIT:

- Consists of non-clinical personnel
- Receives all faxes and phone calls for services that require prior authorization
- Handles issues that can be addressed from a non-clinical perspective:
  - Did you receive my fax?
  - How many visits do I have left under auth R123456?
  - Does xxxx procedure/service require auth?
  - Setting up "shells" for services that must be forwarded to clinical personnel for determination

PRIOR AUTHORIZATION UNIT:

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

Cigna-HealthSpring Toll Free: (800) 453- 4464 and Fax: (615) 291-7545
Cigna-HealthSpring IPA Fax: (615) 401-4660

****Phone hours are 8:00 am-5:00 pm Central Time***

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Sample Authorization Form

Cigna HealthSpring

November 07, 2014 Authorization Number:

Member Name: Test Member2 Member ID Number: Tmtest Member2
POD: <all>
DOB: 07/04/1955 Gender: M
DIAG:

==========

Approval Date: 11/07/2014 Place of Service: Office
Service Start Date: 11/07/2014 Service End Date: 05/07/2015
PCP
Referring Provide
Service Provider: Phone:

The following services have been authorized:

Service Type	Procedure	Units Req	Units App		Dates
		6	6	Visits	-

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Retro Authorizations

- **Authorizations for claims billed to an incorrect carrier** –

  As long as you have *not billed* the claim to Cigna-HealthSpring and received a denial from the incorrect carrier, you can request a retro authorization from Health Services within ***2 business days*** of receiving the RA from the incorrect carrier.

  If the claim has already been submitted to Cigna-HealthSpring and you have received a denial, *the request for retro authorization then becomes an appeal* and you must follow the guidelines for submitting an appeal.

- **Services / Admissions after hours, weekends, or holidays** –

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

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

- ***Please refer to the additional documentation based on your specific service for authorization guidelines and/or requirements.***

Cigna HealthSpring

Standard vs. Urgent Auth Requests

- Urgent Requests:
  - Requests should only be marked as urgent when applying the standard review time frame may seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
  - We will call providers who submit requests not meeting the above criteria to let them know the request is being changed to a standard request.
  - Waiting until the last minute, retro authorization requests, item already delivered, etc. are not valid reasons for an urgent request.

- Standard Requests:
  - Most requests will meet the criteria for a standard request
  - Although the TAT for a response may be 5-7 business days, as long as you submit your request within 2 business days of the start of care (SOC), we will begin the authorization on the SOC.

Cigna HealthSpring

myNexus

- myNEXUS™ is a technology-driven care management company combining intelligent technology with compassionate care
- In collaboration with providers, myNEXUS™ works to effectively and efficiently deliver quality Home Health Care services to members, fostering health and independence in their homes, improving outcomes and reducing readmissions
- myNEXUS™ is delegated for home health utilization management and claims payment for Cigna-HealthSpring of Tennessee
- Includes pre-certification, concurrent and retrospective review
- Authorization is required for all home health services

Cigna HealthSpring

myNEXUS Contact Information

Phone: 844-411-9621

Fax: 844-411-9622

Website: www.mynexuscare.com

Note: All myNEXUS forms are available at the above website.

All Home Health Claims are to be filed with myNEXUS!

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eviCore (fka MedSolutions)

Cigna-HealthSpring and Evicore are working to assist you in providing high-quality, cost-effective usage of advanced imaging.

☑ **Authorization Required**

All outpatient, non-emergent, diagnostic imaging services including:

- MR
- CT
- PET
- Cardiac Imaging (including nuclear cardiac imaging and echocardiography) services

☒ **Authorization Not Required**

- Inpatient radiology
- Radiology testing done in the Emergency Room
- Observation level of care radiology

🚑 **Urgent & Emergent**

When advanced imaging is required in less than 48 hours due to a medically urgent condition, the referring physician's office must **call Evicore at 888-693-3211** for authorization. Evicore will render a decision within an expedited time frame **of receipt** of all necessary information. Please indicate clearly that the notification is for **medically urgent care**.

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eviCore Contact Information

Phone: (888) 693-3211

Fax: (888) 693-3210

Website: www.medsolutionsonline.com

Cigna HealthSpring

Claim Submission

ALL Cigna-HealthSpring guidelines must be met *BEFORE* you submit your claim to Cigna-HealthSpring (i.e., valid authorization number, referral, timely filing, etc). This includes initial claims, secondary claims, claims filed to an incorrect carrier, corrected claims, etc.

- If you have not received a Remittance Advice (RA) from Cigna-HealthSpring within 45 days, please check the status on-line via *HealthSpring Connect*
  - If your **paper** claim is not in our system, submit the claim to Cigna-HealthSpring within 120 days of the DOS.
  - If your **EDI** claim is not in our system, contact your EDI vendor immediately. Claims submitted via EDI are subject to the same timely filing guidelines, regardless of the source of the problem.

- Submit clean and clear forms

Contact your Network Administrator as soon as you discover a trend in claim issues

Cigna HealthSpring

Claim Submission

Paper Claim Submission:

- Mail ALL Paper Claims to:

  Cigna-HealthSpring
  ATTN: CLAIMS DEPARTMENT
  P.O. Box 981706
  El Paso, TX 79998

Electronic Claim Submission:

- Submit ALL Electronic Claims to **Payor ID 63092**
- Emdeon/ Availity (Payor ID: **63092** or **52192**)
- SSIGroup/Proxymed/Medassets/Zirmed/OfficeAlly/GatewayEDI (Payor ID: **63092**)
- Relay Health (**Professional claims** CPID: **2795** or **3839 Institutional claims** CPID: **1556** or **1978**)

Submit all Home Health claims to MyNexus; Phone: 844-411-9621

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Timely Filing Guidelines

Type of Claim	TIMELY FILING POLICY
Initial Filing	120 days from the date of service
Secondary Filing	120 days from the date on the Primary carrier's Remittance Advice (RA)
Filed to Incorrect Carrier	120 days from the denial date on the incorrect carrier's Remittance Advice *
Corrected Claims	180 days from the date on the Cigna-HealthSpring Remittance Advice **

* **Claims filed to an incorrect carrier -** initial claim must have been submitted to the incorrect carrier within carrier's timely filing standards.
  - Contact Health Services for prior authorization number BEFORE submitting claim.
  - Denial from incorrect carrier MUST accompany claim for payment consideration

** **Corrected claims -** Submit the initial claim in it's entirety; i.e. not the correction, only

Claims submitted to Cigna-HealthSpring after these time limits may NOT be considered for payment. Please do not send claims denied for timely filing as appeals

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Electronic Funds Transfer/ Electronic Remittance Advice

- **EFT Enrollment Process:**
  - If you are already enrolled with Emdeon for EFT:
  - Complete the EFT payer add change delete authorization form at http://www.emdeon.com/epayment/enrollment/EFTPCF.php
  - Under the change/add/delete section, the first two columns use the Cigna-HealthSpring information (52192 and Cigna-HealthSpring)
  - The last two columns will be your information
  - The document can be submitted electronically with eSign located at bottom of form window.

- If you are not enrolled with Emdon for EFT, there are two methods to enroll for EFT:
  - Emdeon ePayment Enrollment Form: http://www.emdeon.com/epayment/enrollment/enrollform.php
  - Emdeon ePayment Enrollment Wizard Online: http://www.emdeon.com/eft/index.php

- **ERA Enrollment Process:**
  - Download Emdeon Provider ERA Enrollment Form at the following location: http://www.emdeon.com/resourcepdfs/ERAPSF.pdf
  - Complete and submit ERA Enrollment Form via Email or Fax to Emdeon ERA Group:
    - Email: batchenrollment@emdeon.com
    - Fax: (615) 885-3713

NOTE: ERA enrollment for all Cigna-HealthSpring health plans must be enrolled under Cigna-HealthSpring Payer ID "52192".

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Appeals

An Appeal is the request for Cigna-HealthSpring to review a previously made decision.
Cigna HealthSpring offers two forms of Appeal, Medical Necessity and Reconsideration.

Type of Appeal	APPEAL POLICY
Medical Necessity Appeals (inpatient / SNF / pre-service)	▪ Immediate submission required. ▪ Peer to Peer review may be requested by admitting physician for denials during this time. ▪ Resolution as expeditiously as the Member's health condition requires, but no later than *30 days* from the date the appeal request is received.
Medical Necessity Appeals (post discharge / outpatient)	• Must be submitted within *60 days* of the date of Cigna-HealthSpring's Notice of Denial of Medical Coverage. • Notice of denial must be received prior to submitting appeal.
Reconsiderations (Claim and Payment Appeals)	• Must be received within *180 days* from the date on the Cigna-HealthSpring Remittance Advice. • If appeal is upheld, there is no other level of appeal.

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Solutions Unit for Appeals
Medical Necessity

MAIL appeal to:

Cigna-HealthSpring
ATTN: Solutions Unit
P.O. Box 24087*
Nashville, TN 37202-4087

**Note the P.O. Box for Appeals is different than the P.O. Box for claims*
Do not send certified mail to the P.O. Box. Send certified mail to our physical address

E-MAIL secured appeal to:

FAX-SOL@healthspring.com

**Note when faxing in an appeal the "Request for Appeal or Reconsideration" form is required. Located on line in the Cigna HealthSpring provider manual*

FAX appeal with fewer than 25 pages to:

(615) 931-0149

For additional information regarding appeals, please call 1-800-511-6943

Cigna HealthSpring

Solutions Unit for Appeals

Payment Reconsiderations

MAIL appeal to:

Cigna-HealthSpring
ATTN: Reconsiderations
P.O. Box 20002
Nashville, TN 37202-4087

**Note the P.O. Box for Appeals is different than the P.O. Box for claims*
Do not send certified mail to the P.O. Box. Send certified mail to our physical address

E-MAIL secured appeal to:

FAX-SOL@healthspring.com

**Note when faxing in an appeal the "Request for Appeal or Reconsideration" form is required. Located on line in the Cigna HealthSpring provider manual.*

FAX appeal with fewer than 25 pages to:

(615) 401-4642

For additional information regarding appeals, please call 1-800-230-4642

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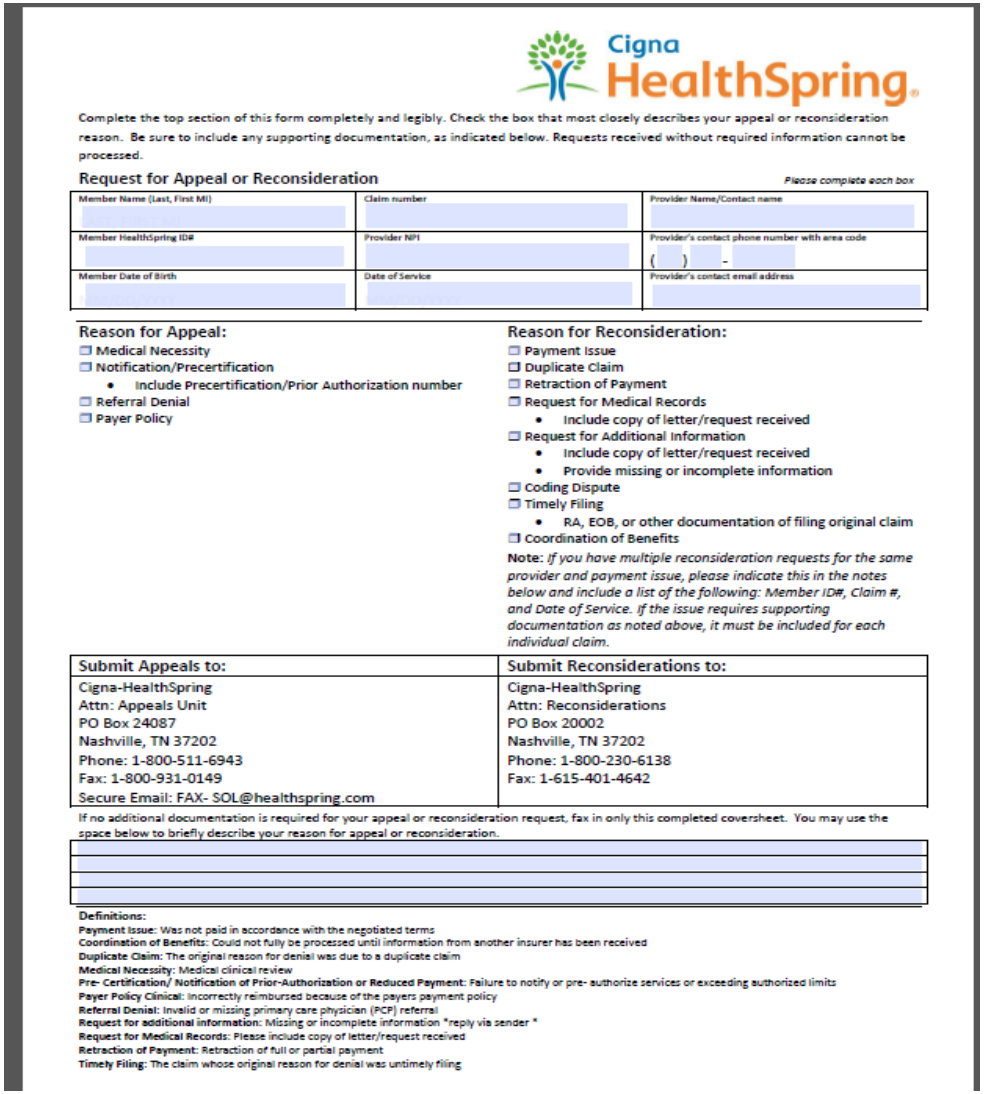
Request for Appeal or Reconsideration Form

Example



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Complete the top section of this form completely and legibly. Check the box that most closely describes your appeal or reconsideration reason. Be sure to include any supporting documentation, as indicated below. Requests received without required information cannot be processed.

Request for Appeal or Reconsideration

Please complete each box

Member Name (Last, First MI)	Claim number	Provider Name/Contact name
Member HealthSpring ID#	Provider NPI	Provider's contact phone number with area code ( ) -
Member Date of Birth	Date of Service	Provider's contact email address

Reason for Appeal:

- ☐ Medical Necessity
- ☐ Notification/Precertification
  - Include Precertification/Prior Authorization number
- ☐ Referral Denial
- ☐ Payer Policy

Reason for Reconsideration:

- ☐ Payment Issue
- ☐ Duplicate Claim
- ☐ Retraction of Payment
- ☐ Request for Medical Records
  - Include copy of letter/request received
- ☐ Request for Additional Information
  - Include copy of letter/request received
  - Provide missing or incomplete information
- ☐ Coding Dispute
- ☐ Timely Filing
  - RA, EOB, or other documentation of filing original claim
- ☐ Coordination of Benefits

Note: *If you have multiple reconsideration requests for the same provider and payment issue, please indicate this in the notes below and include a list of the following: Member ID#, Claim #, and Date of Service. If the issue requires supporting documentation as noted above, it must be included for each individual claim.*

Submit Appeals to:	Submit Reconsiderations to:
Cigna-HealthSpring Attn: Appeals Unit PO Box 24087 Nashville, TN 37202 Phone: 1-800-511-6943 Fax: 1-800-931-0149 Secure Email: FAX- SOL@healthspring.com	Cigna-HealthSpring Attn: Reconsiderations PO Box 20002 Nashville, TN 37202 Phone: 1-800-230-6138 Fax: 1-615-401-4642

If no additional documentation is required for your appeal or reconsideration request, fax in only this completed coversheet. You may use the space below to briefly describe your reason for appeal or reconsideration.

Definitions:

Payment Issue: Was not paid in accordance with the negotiated terms
Coordination of Benefits: Could not fully be processed until information from another insurer has been received
Duplicate Claim: The original reason for denial was due to a duplicate claim
Medical Necessity: Medical clinical review
Pre- Certification/ Notification of Prior-Authorization or Reduced Payment: Failure to notify or pre- authorize services or exceeding authorized limits
Payer Policy Clinical: Incorrectly reimbursed because of the payers payment policy
Referral Denial: Invalid or missing primary care physician (PCP) referral
Request for additional information: Missing or incomplete information *reply via sender *
Request for Medical Records: Please include copy of letter/request received
Retraction of Payment: Retraction of full or partial payment
Timely Filing: The claim whose original reason for denial was untimely filing

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In Summary…

- ✓ *Understand your contract with Cigna-HealthSpring*
- ✓ *Verify Member eligibility*
- ✓ *Bill codes as they appear in the authorization*
- ✓ *Bill according to the rate page of your contract*
- ✓ *Submit claims within 120 days of the date of service*
- ✓ *Follow up on claims after 45 days*
- ✓ *Contact Cigna-HealthSpring as soon as you become aware of an issue*
- ✓ Provider manual: http://www.cigna.com/medicare/healthcare-professionals/provider-manual/

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QUESTIONS????

Cigna HealthSpring℠