



PROVIDER MANUAL

Cigna-HealthSpring® CarePlan (Medicare-Medicaid Plan)

Hidalgo county

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Provider Services Department:

1-877-653-0331

<https://www.cigna.com/medicare/healthcare-professionals/tx-mmp>



Dear Valued Provider and Staff:

I would like to extend a warm welcome and thank you for participating with Cigna-HealthSpring Texas' Network of Participating Providers. We value our relationship with all of our providers and are committed to working with you to meet the needs of your Cigna-HealthSpring patients.

Cigna-HealthSpring has provided managed care services to Medicare and dually-eligible members since 1996. We are excited to extend our passion for offering quality health care delivery to Cigna-HealthSpring CarePlan, Medicare-Medicaid Plan members.

We look forward to working with you to serve the needs of members in order that they may live life well.

Sincerely,

Jay Hurt
Senior Vice President
President – Texas Division
Cigna-HealthSpring

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IMPORTANT PHONE NUMBERS

For quick reference information about Cigna-HealthSpring and the Medicare-Medicaid Plan, providers can visit our website at <http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/index.html> or our Provider Portal at <https://starplus.hsconnectonline.com>.

Note: Users should **not** enter "www" prior to entering the web address for the Provider Portal. Also, providers can call the following resources for more information:

| Cigna-HealthSpring Contacts | |
|--|----------------|
| Provider Services Department | 1-877-653-0331 |
| Member Service Department | 1-877-653-0327 |
| Behavioral Health Services | 1-877-725-2539 |
| Behavioral Health Crisis Hotline | 1-800-959-4941 |
| Claims Status Request | 1-877-653-0331 |
| Compliance Hotline | 1-877-653-0331 |
| Cigna-HealthSpring Automated Eligibility Verification Line | 1-866-467-3126 |
| Service Coordination | 1-877-725-2688 |
| Utilization Management - Concurrent Review | 1-877-725-2688 |
| Utilization Management – Home Health / Long-Term Services and Supports | 1-877-725-2688 |
| Utilization Management - Inpatient Intake Prior Authorization | 1-877-725-2688 |
| Utilization Management – Outpatient Prior Authorization | 1-877-725-2688 |

| External Contacts | |
|---|-----------------|
| 24-Hour Health Information Line | 1-855-418-4552 |
| TMHP Automated Inquiry System (AIS), Eligibility Verification | 1-800-925-9126 |
| Comprehensive Care Program (CCP) | 1-800-846-7470 |
| Dental | |
| > DentaQuest Providers: | 1-888-308-9345: |
| Members: | 1-855-418-1628 |
| Change Healthcare (formerly Emdeon) (EDI) | 1-800-845-6592 |
| Quest Diagnostics | 1-866-697-8378 |

| External Contacts | |
|--|----------------|
| > Clinical Pathology Laboratories (CPL) | 1-800-595-1275 |
| > Laboratory Services (Labcorp) | 1-888-522-2677 |
| > ProPath | 1-866-776-7284 |
| MAXIMUS (Medicaid Managed Care Helpline) | 1-800-964-2777 |
| Medicaid Managed Care Helpline | 1-866-566-8989 |
| Medicaid Managed Care Helpline TDD | 1-866-222-4306 |
| Medical Transportation Program (MTP) - Hidalgo | 1-877-633-8747 |
| Texas Department Of Family And Protective Services (TDFPS) | 1-800-252-5400 |
| Vision | 1-800-879-6901 |

INTRODUCTION

Welcome to Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan). Cigna-HealthSpring, Inc. (Cigna-HealthSpring) and its subsidiaries are wholly-owned by Cigna Corporation (Cigna), a publicly-traded global health service company and the fourth-largest insurer in the United States based on enrollment. Cigna is listed on the New York Stock Exchange (NYSE: CI) and is a component of the S&P 500 Stock Index.

Cigna was formed in 1982 by the merger of the Connecticut General Life Insurance Company and the Insurance Company of North America (INA). In 1792, a group of prominent citizens in Philadelphia formed the Insurance Company of North America (INA), the first marine insurance company in the United States. In 1865, the Governor of Connecticut signed a special act of the General Assembly incorporating the Connecticut General Life Insurance Company (CG). Cigna acquired HealthSpring and its subsidiaries on January 31, 2012.

Cigna-HealthSpring is focused on delivering coordinated care plans to Medicare beneficiaries, with a special focus on improving health care for low-income beneficiaries that qualify for Medicare-Medicaid (dual eligible). Cigna-HealthSpring and Cigna combined have over 402,000 Medicare-Medicaid Enrollees and over 1.25 million Prescription Drug Plan (PDP) Enrollees. Nationwide, we are the:

- > 4th largest Medicare-Medicaid MCO plan
- > 3rd largest Special Needs Plan (SNP) (including Dual, Chronic, and Institutional)
- > 4th largest Special Needs Plan for Institutional Enrollees (those residing in a Nursing Home) (ISNP)

- > 4th largest Special Needs Plan for Dual Eligibles (D-SNP)
- > 4th largest Special Needs Plan for Medicare Beneficiaries with Chronic Conditions (Cigna-HealthSpring covers individuals with Diabetes)
- > 6th largest Prescription Drug Plan

Cigna-HealthSpring's history officially began in 1996 when healthcare entrepreneur Herb Fritch saw an opportunity in a struggling Nashville health plan called Health Net, which offered Medicare and some commercial group plans. This was a time of unprecedented downturn in the Medicare industry due to falling government reimbursements, and most plans were pulling out of the business altogether. Mr. Fritch personally carried 15% of the original funding. Herb took ownership of the plan in September 2000, and within a few months, he and a new management team had halted and reversed its losses. In October 2001, the plan's name was changed to HealthSpring to reflect its new direction and growth.

Herb's approach was two-pronged: 1) a focus on the specific healthcare needs of people on Medicare and the dual eligible population, and 2) engaging physicians in a model that established the primary care physician (PCP) as the Provider that is responsible for the coordination of care with an emphasis on preventive care. He committed to this course at a time when most health plans were leaving the Medicare market and had given up attempting meaningful partnerships with physicians.

Medicare-Medicaid Plan Program Overview

We are pleased to announce that, beginning March 1, 2015, Cigna-HealthSpring will be participating in the Medicare-Medicaid Alignment Initiative. The goal of this initiative is to better serve both community and institutional based individuals who are eligible for both Medicare and Medicaid (dual-eligible enrollees). The initiative is to develop a service delivery model that improves care coordination of services, improves quality of care, and reduces cost.

Providers should use this provider manual in conjunction with the Cigna-HealthSpring participating provider agreement to understand important participation requirements such as:

- > Services that are covered under Cigna-HealthSpring
- > How to determine Member eligibility
- > How to access health care services within Cigna-HealthSpring's network
- > How to file claims with Cigna-HealthSpring
- > Provider roles and responsibilities
- > Cigna-HealthSpring's Quality Management program
- > Member roles and responsibilities

This provider manual is current as of its publication date. Cigna-HealthSpring reserves the right to make updates as necessary and will make updates available to providers promptly.

Cigna-HealthSpring conducts its business affairs in accordance with Federal and State laws.

Cigna-HealthSpring takes the privacy and confidentiality of Members' health information seriously. Cigna-HealthSpring complies with the Health Insurance Portability and

Accountability Act of 1996 (HIPAA) and Texas regulatory requirements.

Objectives of the MMP Program

The objective of the MMP Program is to:

- > Make it easier for clients to get care
- > Promote independence in the community
- > Eliminate cost shifting between Medicare and Medicaid
- > Achieve cost savings for the State and Federal government through improvements in care and coordination
- > Require one health plan to be responsible for the full array of service.

Member Confidentiality

At Cigna-HealthSpring, we know our members' privacy is extremely important to them, and we respect their right to privacy when it comes to their personal information and health care. We are committed to protecting our members' personal information. Cigna-HealthSpring does not disclose member information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law.

When a member joins a Cigna-HealthSpring plan, we want you to know the steps we have taken to protect the privacy of our members. This includes how we gather and use their personal information. Cigna-HealthSpring's privacy practices apply to all of Cigna-HealthSpring's past, present, and future members.

When a member joins the Cigna-HealthSpring Medicare-Medicaid Plan, the member agrees to give Cigna-HealthSpring access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of healthcare to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium,

or in any form or medium. Access to PHI allows Cigna-HealthSpring to work with providers, like yourself, to decide whether a service is a covered service and pay your clean claims for covered services using the members' medical records. Medical records and claims are generally used to review treatment and to do quality assurance activities. It also allows Cigna-HealthSpring to look at how care is delivered and carry out programs to improve the quality of care Cigna-HealthSpring's members receive. This information also helps Cigna-HealthSpring manage the treatment of diseases to improve our members' quality of life.

Cigna-HealthSpring's members have additional rights over their health information. **They have the right to:**

- Send Cigna-HealthSpring a written request to see or get a copy of information about them, or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer Cigna-HealthSpring's member to the source of the information.
- Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.
- Receive an accounting of Cigna-HealthSpring's disclosures of their medical information, except when those disclosures are for treatment, payment or health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect member PHI.

Role of the Primary Care Provider (PCP)

Cigna-HealthSpring members must select an in-network Primary Care Provider (PCP) to oversee their care. PCPs are normally selected by the member during the enrollment process. If a member does not select a PCP during the enrollment process, one will be auto-assigned to them based on PCP proximity by HHSC's enrollment broker, MAXIMUS. Members may change PCPs at any time by calling the Cigna-HealthSpring Member Service Department at **1-877-653-0327**.

- A PCP may specialize in the following specialties:
 - General practice
 - Family practice
 - Internal medicine
 - Obstetrics/Gynecology (OB/GYN)
 - Pediatrics

When practicing under the supervision of a participating Cigna-HealthSpring physician, advanced practice nurses

(APNs) may serve as PCPs. Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Community Clinics may also serve as PCPs. Specialty Care Providers serve as PCPs under specific circumstances. The circumstances under which this may occur are discussed in the Member Service section of this provider manual.

The PCP serves as the "medical home" or the entry point for access to health care services. The PCP provides or arranges for all medically necessary primary care services and refers members for specialty care when necessary. Cigna-HealthSpring PCPs are responsible for the following:

- Verifying member eligibility prior to rendering services
- If indicated, obtaining authorizations prior to rendering services
- Managing the health care needs of all assigned members
- Providing continuity of care for members (see section Continuity of Care)
- Ensuring that each member receives medically necessary treatment based on the member's condition
- Providing behavioral health services within his or her scope of practice
- Complying with Cigna-HealthSpring's prior authorization procedures
- Using appropriate ancillary services
- Referring members to participating Cigna-HealthSpring providers
- Referring members for a second opinion, if requested
- Complying with Cigna-HealthSpring's emergency care procedures
- Notifying Cigna-HealthSpring of any barriers to a member's care
- Adhering to Cigna-HealthSpring's medical record standards as outlined in this provider manual
- Complying with Cigna-HealthSpring's Quality Management and Utilization Management programs
- Complying with preventive screening and clinical guidelines
- Being culturally sensitive to members
- Complying with Cigna-HealthSpring's credentialing and re-credentialing requirements
- Complying with Cigna-HealthSpring's access and availability standards as outlined in this provider manual
- Using a National Provider Identification (NPI) number
- Billing services in accordance with the billing procedures outlined in this provider manual
- When billing for services provided, using specific coding to capture the acuity and complexity of a

member's condition and ensuring that submitted codes are supported by the medical record

- Notifying Cigna-HealthSpring and HHSC's administrative services contractor of any changes to the provider's address, telephone number, group affiliation, etc.

Role of the Specialty Care Provider

Specialty Care Providers play an essential role in caring for members. A Cigna-HealthSpring Specialty Care Provider is responsible for providing health care services to members who require care beyond the capabilities of a PCP. Specialty Care Providers must render covered health services within the scope of their practice and license, in the same manner, according to the same standards, and within the same time availability as offered to their other patients. It is the responsibility of the Specialty Care Provider to communicate their findings and recommendations with each member's PCP in order to promote coordination and continuity of care.

Cigna-HealthSpring Specialty Care Providers are responsible for the following:

- Verifying member eligibility prior to rendering services
- If required, obtaining authorizations prior to rendering services
- Providing specialty health care services to members as needed
- Collaborating with the member's PCP to ensure continuity of care and appropriate treatment
- Providing consultative and follow-up reports to the PCP in a timely manner
- Referring members to participating Cigna-HealthSpring providers
- Complying with Cigna-HealthSpring's prior authorization procedures
- Complying with Cigna-HealthSpring's access and availability standards as outlined in this provider manual
- Complying with Cigna-HealthSpring's Quality Management and Utilization Management programs
- Adhering to Cigna-HealthSpring's medical record standards as outlined in this provider manual
- Using a National Provider Identification (NPI) number
- Billing services to Cigna-HealthSpring in accordance with the billing procedures outlined in this provider manual
- When billing for services provided, using specific coding to capture the acuity and complexity of a member's condition and ensuring that submitted codes are supported by the medical record

Missed Appointments by Members

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Cigna-HealthSpring requests providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact may be by telephone, allowing the provider to educate the member about the importance of keeping appointments. It's also a good time for the provider to encourage the member to reschedule the appointment.

Cigna-HealthSpring members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, providers can call Provider Services at **1-877-653-0331** or Cigna-HealthSpring's Behavioral Health Team at **1-877-725-2539**. Our staff contacts the member and offers more extensive education through our case management team. It is imperative that our members recognize the importance of maintaining preventive health visits and following their PCP's recommended plan of care.

Role of the Long-Term Services and Supports (LTSS) Provider

Long-Term Services and Supports (LTSS) providers deliver a continuum of care and assistance ranging from in-home and Long-Term Services and Supports. At times, LTSS is necessary as a preventative service to avoid more expensive hospitalizations, emergency room visits, or institutionalization. At other times, LTSS is necessary to assure that members maintain the highest level of functioning possible in the least restrictive setting. A member's need for LTSS to assist with the activities of daily living is equally important as needs related to a medical condition.

LTSS providers are responsible for providing covered services to members, within the scope of their Cigna-HealthSpring participating provider agreement and within the scope of their license (if applicable). Other LTSS responsibilities include:

- Verifying member eligibility prior to rendering services as well as monthly if the provider is providing on-going treatment or services
- Obtaining authorizations prior to rendering services
- Providing continuity of care
- Ensuring on-going continuity of care between the member's Service Coordinator and his/her PCP
- Coordinating benefits for Dually eligible Members and ensuring that Medicare benefits are accessed prior to accessing Medicaid benefits or HCBS STAR+PLUS Waiver Program services;
- Notifying Cigna-HealthSpring of a change in the member's physical condition or eligibility

- > Using a National Provider Identification (NPI) number or the HHSC-issued Alternative provider Identification (API) number, whichever is appropriate
- > Billing and reporting services in compliance with the LTSS HCPCS Codes and Modifiers Matrix
- > Employment Assistance Responsibilities-Providers must develop and update quarterly a plan for delivering employment assistance services
- > Supported Employment Responsibilities-Provider must develop and update quarterly a plan for delivering supported employment services
- > Community First Choice services must be delivered in accordance with the Member's service plan

The Service Coordination Program, under the supervision of healthcare professionals at both the Director and Vice President levels, is a key to Cigna-HealthSpring's success.

The Service Coordination staff:

- > Assesses each member's needs
- > Coordinates services to ensure appropriate utilization of health care resources
- > Assists members in locating community resources to meet non-healthcare needs
- > Performs on-going evaluations of members' needs
- > Engages with healthcare providers to ensure a holistic approach to treatment
- > Collaborates with internal departments, such as Quality Improvement, Appeals and Grievances, Provider Relations and Member Service, Utilization Management, and the Office of the Medical Director

These duties are to improve members' access to services and health outcomes, while ensuring proper allocation of benefits.

Within 30 days of enrollment, Service Coordination teams contact all members telephonically to complete an assessment and triage enrollees. Members are assigned a level and contacted according to the following criteria

Role of Service Coordinator

Cigna-HealthSpring's Health Services Department manages the medical and behavioral health services of our members through a comprehensive, preventative, and therapeutic delivery system. Our goal is to ensure for every member quality services, which are timely and clinically appropriate yet cost-effective and in the least confining environment. To reduce avoidable admissions into acute and long term care, we proactively manage chronic conditions. We strive to improve each member's quality of life by helping them access community and governmental resources to meet any unaddressed psychological or social needs

| Member Level | Determination of Assignment | Service Coordinator Requirements and Requisite Number and Types of Visits |
|--------------|--|---|
| Level 1 | <ul style="list-style-type: none"> > All SPW members > Non SPW members who have had 3 or more claims for unique hospitalizations (non BH) in the last 9 months > Non SPW members who have had 3 or more authorizations for unique hospitalizations (non BH) in the last 6 months > Pediatric members with PDN or PCS services > A member will move to a lower level if they have not been hospitalized for the last 6 months or if they have lost their SPW eligibility. Pediatric members will move to a lower level if they no longer receive PDN or PCS services. | Assigned to a single identified RN and seen a minimum of twice per year face-to-face. |
| Level 2 | <ul style="list-style-type: none"> > All members who do not meet the criteria for Level 1 above are assigned to a Level 2 Service Coordinator. | Assigned to a single identified LVN or MSW and seen a minimum of once per year face-to-face with an additional telephonic contact yearly. |

Role of the Pharmacy Provider

Cigna-HealthSpring members may go to any Cigna-HealthSpring network pharmacy.

Cigna-HealthSpring Pharmacy providers are responsible to:

- Adhere to the Cigna-HealthSpring formulary
- Adhere to a Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure members receive all medications for which they are eligible
- Coordinate benefits when member also receives other insurance benefits

Role of Main Dental Home

Dental plan Members may choose their in-network Main Dental Homes. Dental plans assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home.

A Main Dental Home serves as the Member's main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. In-network Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes.

How to Help a Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of a Member's Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within 5 business days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at 1-800-964-2777.

Network Limitations

Cigna-HealthSpring has no network limitations on referrals from PCPs to in-network Specialty Care Providers or Ancillary providers. Use of a specific referral form is not necessary, as long as the PCP is directing care. Additionally, female members may seek obstetrical and gynecological services from any participating OB/GYN without a referral from their PCP. A member also may choose an OB/GYN as her PCP from the list of participating Cigna-HealthSpring providers.

Cigna-HealthSpring members may select and have access to, without a Primary Care Provider referral, a network Ophthalmologist or Therapeutic Optometrist to provide eye health care services other than surgery.

Administrative, Medical, and Reimbursement Policy Changes

From time to time, Cigna-HealthSpring may amend, alter, or clarify its policies. Examples of this include, but are not limited to: regulatory changes, changes in medical standards, and modification of covered services. Specific Cigna-HealthSpring policies and procedures may be obtained by calling our Provider Services Department at **1-877-653-0331**.

Cigna-HealthSpring will communicate changes to the provider manual through the use of a variety of methods including but not limited to:

- Annual provider manual updates
- Letter
- Facsimile
- Email
- Provider Newsletters

Providers are responsible for the review and inclusion of policy updates in the provider manual and for complying with these changes upon receipt of these notices.

Provider Marketing Guidelines

The below is a general guideline to assist Cigna-HealthSpring Providers who have contracted with multiple Medicare-Medicaid plans and are accepting Medicare FFS patients in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare-Medicaid plans to prohibit providers from steering, or attempting to steer an undecided potential enrollee toward a specific plan, or limited number of plans, offered either by the plan sponsor or another sponsor, based on the financial interest of the provider or agent. Providers should remain neutral parties in assisting plans to market to beneficiaries or assisting in enrollment decisions.

The Provider can:

- Mail/call their patient panel to invite patients to general Cigna-HealthSpring-sponsored educational events to learn about the Medicare and/or Medicare-Medicaid program. This is not a sales/marketing meeting. No sales representative or plan materials can be distributed. Sales representative cards can be provided upon request.
- Mail an affiliation letter one time to patients listing only Cigna-HealthSpring.
- Have additional mailings (unlimited) to patients about participation status but must list all participating

Medicare-Medicaid plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior CMS approval and the agreement of all plans listed.

- Notify patients in a letter of a decision to participate in a Cigna-HealthSpring sponsored programs.
- Utilize a physician/patient newsletter to communicate information to patients on a variety of subjects. This newsletter can have a Cigna-HealthSpring corner to advise patients of Cigna-HealthSpring information. Provide objective information to patients on specific plan formularies, based on a patient's medications and health care needs.
- Refer patients to other sources of information, such as the State Health Insurance Assistance programs, Cigna-HealthSpring marketing representatives, State Medicare-Medicaid, or Texas Client Enrollment Services, **1-800-Medicare** to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Display and distribute in provider offices Cigna-HealthSpring MA and MA-PD marketing materials, excluding application forms. The office must display or offer to display materials for all participating MA plans.
- Notify patients of a physician's decision to participate exclusively with Cigna-HealthSpring for Medicare-Medicaid or to close panel to original Medicare FFS if appropriate.
- Record messages on our auto dialer to existing Cigna-HealthSpring members as long as the message is not sales related or could be construed as steerage. The script must be reviewed by Cigna-HealthSpring Legal /Government programs.
- Have staff dressed in clothing with the Cigna-HealthSpring logo.
- Display promotions items with the Cigna-HealthSpring logo.
- Allow Cigna-HealthSpring to have a room/space in provider offices completely separate from where patients have a prospect of receiving health care, to provide beneficiaries' access to a Cigna-HealthSpring sales representative.

The Provider cannot:

- Quote specific health plan benefits or cost share in patient discussions.
- Urge or steer towards any specific plan or limited set of plans.

- Collect enrollment applications in physician offices or at other functions.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are disenrolling from the health plan to encourage re-enrollment in a health plan.
- Mail notifications of health plan sales meetings to patients.
- Call patients to invite patients to sales and marketing activity of health plan.
- Cannot advertise using Cigna-HealthSpring's name without Cigna-HealthSpring's prior consent and potentially CMS approval depending upon the content of the advertisement.

Member Assignment to new PCP

Cigna-HealthSpring Primary Care Physicians have a limited right to request a member be assigned to a new Primary Care Physician. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- The member is disruptive, unruly, threatening, or uncooperative to the extent that member seriously impairs Cigna-HealthSpring's or the provider's ability to provide services to the member or to obtain new members and the aforementioned behavior is not caused by a physical or behavioral health condition.
- Threats of physical harm to a provider and/or office staff.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- The member is steadfastly refusing to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the managed care organization to coordinate treatment of the underlying medical condition).

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education

and counseling and, if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied through reasonable efforts, and the PCP feels the relationship has been irreparably harmed, the PCP should complete the member transfer request form and submit it to Cigna-HealthSpring.

Cigna-HealthSpring will research the concern and decide if the situation warrants requesting a new PCP assignment. If so, Cigna-HealthSpring will document all actions taken by both the provider and Cigna-HealthSpring to cure the situation. This may include member education and counseling. A Cigna-HealthSpring PCP cannot request a disenrollment based on adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

Procedure

- Once Cigna-HealthSpring has reviewed the PCP's request and determined that the physician/patient relationship has been irreparably harmed, the member will receive a minimum of thirty (30) day notice that the physician/patient relationship will be ending. Notification must be in writing, by certified mail, and Cigna-HealthSpring must be copied on the letter sent to the patient.
- The physician will continue to provide care to the member during the thirty (30) day period or until the member selects or is assigned to another physician. Cigna-HealthSpring will assist the member in establishing a relationship with another physician.
- The physician will transfer, at no cost, a copy of the medical records of the member to the new PCP and will cooperate with the member's new PCP in regard to transitioning care and providing information regarding the member's care needs.

A member may also request a change in PCP for any reason. The PCP change that is requested by the member will be effective the first (1st) of the month following the receipt of the request, unless circumstances require an immediate change.

Focus Studies and Utilization Management reporting requirements.

Cigna-HealthSpring's quality team is involved in conducting clinical and service utilization studies that may require a medical record review. This gives us an opportunity to conduct gap analysis of the date and to look for and share opportunities for improvement in our network providers.

COVERED SERVICES

Medicare-Medicaid Managed Care Covered Services

Cigna-HealthSpring CarePlan provides a benefit package to Medicare-Medicaid Plan members that include all medically necessary services covered under original Medicare/Medicaid programs. The following list provides an overview of these benefits. Providers can refer to the member's Evidence of Coverage (EOC) for a more inclusive listing of limitations and exclusions. Medically necessary services that are not covered under original Medicare may be covered under managed Medicaid.

- Ambulance services
- Inpatient admissions to Acute Care facilities
- Skilled Nursing Facilities
- Inpatient behavioral health services Outpatient behavioral health services
- Psychiatry services
- Substance use disorder treatment services
- Residential services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Home health care services
- Laboratory services
- Optometry, glasses, and contact lenses, if medically necessary
- Audiology services for monaural hearing aids
- Podiatry
- Primary care services
- Prescription medications of approved formulary (no limitation)
- Preventive services including an annual adult well check for members 21 years of age and over
- Radiology, imaging, and x-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision care

Cigna-HealthSpring Medicare-Medicaid Plan provides multiple covered screening services. Screening for certain disease process is very important for early detection and treatment.

Cigna-HealthSpring will provide Medicaid wrap-around services for outpatient drugs, biological products, certain

limited home health supplies (LHHS), and vitamins and minerals as identified on the HHSC drug exception file to STAR+PLUS Members under a non-risk, cost settlement basis, as described in Attachment A, Section 10.16, “Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products.” Refer to HHSC’s UMCM, Chapter 2.2, “Pharmacy Claims Manual,” for additional information regarding the claims processing requirements for these. Wrap-Around Services means services for Dual Eligible Members that are covered by Medicaid: (1) when the Dual Eligible Member has exceeded the Medicare coverage limit; or (2) that are not covered by Medicare.

Behavioral Health Covered Services

Behavioral Health Services means covered services for the treatment of mental, emotional, or chemical dependency disorders. Cigna-HealthSpring provides a behavioral health benefit package to Medicare-Medicaid Plan members that includes all medically necessary services covered under the traditional, fee-for-service Medicaid programs. The following list provides an overview of these benefits. Providers can refer to the current TMPPM and the bi-monthly Texas Medicaid Bulletins for a more inclusive listing of limitations and exclusions. Behavioral Health Services, including:

- Inpatient mental health services for adults and children
- Outpatient mental health services for adults and children
- Partial Hospitalization (PHP) and Intensive Outpatient Services (IOP)
- Psychiatry services
- Counseling services for adults (21 years of age and over)
- Electroconvulsive therapy (ECT)
- Psychological Testing
- Targeted Case Management Services
- Mental Health Rehabilitation Services
- Cognitive Rehabilitation Therapy
- Employment Assistance and Supportive Employment
- Community First Choice (CFC)

Members with Attention-Deficit Hyperactivity Disorder (ADHD)

Substance use disorder treatment services, including:

- Detoxification services
- Medication assisted therapy (MAT)
- Residential services, including
- Detoxification services

- Substance use disorder treatment (including room and board)

Cigna-HealthSpring provides an integrated health delivery model that utilizes all necessary resources and providers to promptly identify precipitating factors that influence members’ overall health. Cigna-HealthSpring ensures that behavioral health services are available at the appropriate time and in the least restrictive setting possible, so members can safely access care without adversely affecting their physical and/or behavioral health. Communication among behavioral health and physical health providers is a key to accomplishing this goal and ensuring quality of care. This facilitates collaboration among providers, allowing them to work jointly as they coordinate all of the members’ needs efficiently. This collaborative approach between behavioral health and physical health providers promotes coordination of care activities.

Member Access to Behavioral Health Services

Cigna-HealthSpring members may access behavioral health services in several ways. They are as follows:

- Through the PCP. A PCP may provide treatment within the scope of his or her practice and licensure using the DSM-V multi-axial classifications.
- Through a provider referral. A PCP or Specialty Care Provider may refer a Cigna-HealthSpring member to an in-network Behavioral Health provider.

Through a self-referral. A member may self-refer for behavioral health services to any in-network Behavioral Health provider. To identify an in-network Behavioral Health provider, members can call their Service Coordinator at **1-877-725-2688**. Also, members may call the Cigna-HealthSpring Member Service Department at **1-877-653-0327**, Monday through Friday, 8 a.m. to 8 p.m. Central Time. Members in crisis can call Cigna-HealthSpring’s Crisis Hotline at **1-800-959-4941**, seven (7) days a week, twenty-four (24) hours per day.

Through Service Coordinator referral. New members are assessed by Service Coordinators using the Health Risk Assessment (HRA). A positive answer to the HRA question “In the past 3 months would you describe yourself as depressed?” prompts a question to the member regarding their willingness to participate in a depression screening utilizing the PHQ9 screening tool. A Member scoring 10 or higher on the embedded PHQ9 screening is provided with a behavioral health referral. The member is informed that participation in the screening and acting upon any resulting referral are completely voluntary.

All Behavioral Health Referrals and Case Management Services are addressed by the Cigna-HealthSpring Behavioral Health Department. The Behavioral Health Department is comprised of licensed mental health clinicians who are able to assess a member’s needs, assist with accessing services, monitor treatment following discharge from an inpatient facility, assist providers with discharge planning needs, and provide

resources for resolving psychosocial needs. A licensed clinician is available to speak with a member or provider to address treatment needs. In addition to licensed clinicians, the Behavioral Health Department includes experienced Behavioral Health Utilization Review Nurses who are responsible for reviewing and authorizing behavioral health services.

For the Tarrant service area, the Behavioral Health Department also includes two co-located clinicians with Tarrant County MHMR who are available to assist with linking members to services provided by the Local Mental Health Authority (MHMR) and coordinating mobile crisis interventions as needed.

Behavioral Health providers should screen Cigna-HealthSpring members for co-existing medical conditions. Behavioral Health providers may provide physical health services only if they are licensed to do so. When screening is complete and with the member's consent, Behavioral Health providers should refer members with known, suspected, or untreated physical health problems or preventive care needs to their PCP for examination and treatment. Behavioral Health providers should communicate concerns regarding a member's medical condition to the PCP and work collaboratively on a plan of care. Information should be shared among Cigna-HealthSpring behavioral health providers and physical health providers to ensure continuity of care. With the member's consent, the primary care and behavioral health providers are encouraged to share pertinent history and test results in a timely manner and document review of the information received in the clinical record. Specifically, behavioral health providers must provide the PCP with a written summary report following the initial visit and quarterly thereafter.

Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM)

For the purposes of these services Severe and Persistent Mental Illness (SPMI) shall be defined as a mental illness with complex symptoms that require ongoing treatment and management. Severe Emotional Disturbance (SED) shall be defined as a diagnosed condition that disrupts daily functioning.

Provider Requirements and Responsibilities for MHR and TCM Services:

- All providers delivering Mental Health Rehab and / or Mental Health Targeted Case Management must undergo all applicable trainings as directed by HHSC before delivering and / or supervising clinicians delivering these services. Providers will be required to attest to Cigna-HealthSpring regarding the completion of these trainings on at least an annual basis, and as requested by Cigna-HealthSpring. Providers will attest to all trainings using the attestation form provided to them by Cigna-HealthSpring.

1. Training courses include, but are not limited to the CANS assessment, ANSA assessment, Illness Management and recovery, Assertive Community Treatment, Individual Placement and Supports Supported Employment, Permanent Supportive Housing, Social Skills and Aggression Replacement Techniques, Preparing Adolescents for Young Adulthood, Seeking Safety, Nurturing Parenting Program, Barkley's Defiant Child/Defiant Teen, and Wraparound Planning Process.
 - Services must be authorized using the Department of State Health Services Resiliency and Recover Utilization Management Guidelines (RRUMG)
 - Attestation from Provider that organization has the ability to provide, either directly or through sub-contract, the members with the full array of MHR and TCM services as outlined in the RRUMG.
 - Provider must review a member's plan of care for Mental Health Rehabilitative Services in accordance with the RRUMG to determine if a change in the member's condition or needs warrants a reassessment or change in service. A new plan of care must be submitted to Cigna-HealthSpring for authorization review.

Mental Health Rehabilitative Services Qualified Providers

Qualified Mental Health Professionals for Community Services (QMHP-CS). The requirement minimums for a QMHP-CS are as follows:

- Demonstrated competency in the work to be performed
- Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention
- Be a Registered Nurse (RN)

A Licensed Practitioner of the Healing Arts (LPHA) is automatically certified as a QMHP-CS. A Community Services Specialist (CSSP), a Peer Provider (PP), and a Family Partner (FP) can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA. Additionally, a PP must be a certified peer specialist, and an FP must be a certified family partner.

Mental Health Targeted Case Management Qualified Providers

A qualified provider of mental health targeted case management must:

- > Demonstrate competency in the work performed
- > Possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention
- > Be a Registered Nurse (RN)

Individuals authorized to provide case management services prior to August 31, 2004, may provide case management services without meeting the minimum qualifications described above if they meet the following criteria:

- > High school diploma or high school equivalency;
- > Three continuous years of documented full-time experience in the provision of mental health case management services as of August 30, 2004; and
- > Demonstrated competency in the provision and documentation of case management services.
- > A case manager must be clinically supervised by another qualified case manager who meets the criteria.

The MCO is prohibited from establishing additional supervisory protocols with respect to the above-listed provider types. Further, the MCO may not require the name of a performing provider on claims submitted to the MCO if that provider is not a type that enrolls in Medicaid (such as CSSPs, PPs, FPs, non-LPHA QMHPs, and Targeted Case Managers).

Employment Assistance and Supported Employment Responsibilities

Providers must develop and update quarterly a plan for delivering employment assistance and supported employment services.

Freestanding Psychiatric Facilities for children and adults in MMP

Cigna-HealthSpring is responsible for reviewing and authorizing inpatient hospital services, including services provided by in a freestanding psychiatric facility.

PCPs are Encouraged to Select from the multitude of Tools for Behavioral Health

PCPs are encouraged to explore and select the most appropriate behavioral health tools available. Some tools that you may find helpful include the CAGE and CAGE-AID. The CAGE questionnaire is used to test for alcohol abuse and dependence in adults. The CAGE-AID version of the tool has been adapted to include drug use. These tools are not used to diagnose diseases, but only to indicate whether a problem might exist. The GAD-7 is a seven-item screening instrument for generalized anxiety disorder. However, it has also proven

to have good sensitivity and specificity as a screener for panic disorder, social anxiety, and post-traumatic stress disorder. The PHQ-9 Patient Depression Questionnaire may assist in determining potential Major Depressive Disorders and other Depressive Disorders. Cigna-HealthSpring's Behavioral Health team is available to you to assist with questions, referrals, or resources. You may reach them by calling **1-877-725-2539**.

Consent for Disclosure and Sharing of Information between Behavioral Health Provider and PCP

PCPs and Behavioral Health providers are required to obtain consent for the disclosure of information from the member permitting the exchange of clinical information between the Behavioral Health provider and the member's physical health provider.

Prior Authorization Requirements for Behavioral Health Services

Behavioral Health providers should notify Cigna-HealthSpring when they are initiating treatment. The notification process provides an opportunity to verify eligibility, confirm benefits, obtain prior authorization if necessary, and update the member's electronic file within Cigna-HealthSpring's system.

- > The following services do not require prior authorization from Cigna-HealthSpring:
- > Medication management – authorization is required after the 30th visit; and
- > Thirty (30) outpatient visits per year – additional outpatient visits require prior authorization.

The following behavioral health services require prior authorization from Cigna-HealthSpring:

- > In-patient Hospitalization –Cigna-HealthSpring must be notified within 1 business day of admission
- > Partial Hospitalization and Intensive Outpatient Programs – must be authorized before initiating services
- > Residential Treatment Services
- > Additional outpatient visits, beyond the initial thirty (30) – providers must submit an extended therapy authorization request by the twenty-fourth (24th) visit
- > Psychological Testing, Neuropsychological Testing, ECT
- > Ambulatory Detox, Residential Detox, Residential Treatment
- > Medication Assisted Therapy – notification only

Prior authorization forms for behavioral health services can be obtained by visiting our website

<http://www.cigna.com/medicare/healthcare-professionals/tx-mmp>, submit electronically via Provider Portal at <https://starplus.hsconnectonline.com> or calling Provider Services at **1-877-653-0331**.

Continuity of Care Follow-Up

When a member does not keep a scheduled appointment, the Behavioral Health provider should contact the member to reschedule the missed appointment within twenty-four (24) business hours. Providers should not bill members for missed appointments.

To ensure continuity of care, Cigna-HealthSpring requires its Behavioral Health providers to follow-up with members on an outpatient basis within seven (7) days after discharge from an inpatient setting. Also, behavioral Health providers should follow-up telephonically or face-to-face with members who are non-compliant with medications and/or treatment. The Cigna-HealthSpring Behavioral Health Department is available to assist with coordinating follow-up appointments following discharge from an inpatient facility.

Medical Record and Documentation

When filing claims for behavioral health services, providers must use the DSM-V multi-axial classification system and report a complete diagnosis using the five (5) Axes. Behavioral health services require the development of a treatment plan. Documentation must always indicate date of service. Co-morbid physical health conditions should be noted in Axis 3 of the diagnosis.

Coordination with Local Mental Health Authority (LMHA)

The Local Mental Health Authority (LMHA) offers an array of clinical and support services for members with behavioral health conditions. In the state of Texas the LMHA is the local Mental Health Mental Retardation (MHMR) agency in the service delivery area. Cigna-HealthSpring coordinates with the LMHA and State psychiatric facilities regarding admission and discharge planning, treatment objectives and projected length of stay for members committed by a court of law to a State psychiatric facility. Cigna-HealthSpring Health Services Behavioral Health staff has access to two MHMR staff members in Tarrant County who are able to coordinate covered services through Tarrant County MHMR. In Hidalgo, the Behavioral Health Case Managers work closely with the local MHMR agencies, Tropical Texas MHMR and Border Region MHMR, to assist members with accessing services.

Court Ordered and Department of Family Protective Services (DFPS)-Directed Services

Cigna-HealthSpring will provide inpatient psychiatric services to members who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 62 and 63 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities based on medical necessity. A request for prior authorization of court-ordered or DFPS-directed services must be submitted to Cigna-HealthSpring no later than one (1) calendar days after the date on which the service began. Prior authorization requests must be accompanied by a copy of the court

document signed by the judge. The requested services will be reviewed for medical necessity. For more information about coordination with DFPS, providers can refer to the provider Responsibilities section of this provider manual.

Medicare has a certain amount of allowable inpatient days. Medicaid does as well. If the Medicare allowable days are exhausted, the reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. The spell of illness days will be counted concurrently with the Medicare allowable days. This means the Medicare and Medicaid days may both be exhausted.

Exceptions to the spell of illness are as follows:

- A prior-approved solid organ transplant. The 30-day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.

Health and Behavioral Assessment and Intervention (HBAI) Services

HBAI services are for Medicaid clients who are 20 years of age and younger. HBAI services are designed to identify and address the psychological, behavioral, emotional, cognitive and social factors important to prevention, treatment or management of physical health symptoms. HBAI services may be a benefit when the client meets all of the following criteria:

- Underlying physical illness or injury
- Documented indications that biopsychosocial factors may be significantly affecting the treatment or medical management of an illness or injury
- The client is alert, oriented and depending on age, has the capacity to understand and respond meaningfully during the in-person evaluation
- The client has a documented need for psychological evaluation or intervention to successfully manage his/her physical illness and activities of daily living
- The assessment is not duplicative of other provider assessments

HBAI Services

The HBAI benefits include a health and behavioral assessment and reassessment. It also includes treatment services which could consist of cognitive, behavioral, social or psychophysiological interventions designed to improve specific disease related problems.

HBAI services can be provided to an individual client, a client as part of a group, a client with the family present, or the family without the client present.

HBAI assessment and reassessment services are limited to maximum of four 15-minute units (one hour) per client, per rolling 180 days, any provider. HBAI intervention services are limited to a maximum of sixteen 15-minute units (four hours), per client, per rolling 180 days, any provider.

HBAI provider qualifications:

- HBAI services are provided by a license practitioner of the healing arts (LPHA) who is co-located in the same office or building complex as the client's primary care provider (PCP).

HBAI services may be reimbursed to the following provider types:

- Physician Assistant
- Nurse Practitioner/Clinical Nurse Specialist
- License Professional Counselor/Licensed Marriage and Family Therapist
- Comprehensive Care Program (CCP) Social Worker
- Physician (D.O. or M.D.)
- Physician Group
- Psychologist
- Psychology Group
- Licensed Clinical Social Worker
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinic (Freestanding/independent or Hospital Based)

Cigna-HealthSpring Behavioral Health Provider Relations

Provider Relations Representatives are available to all Cigna-HealthSpring Behavioral Health Providers. Provider Relations Representatives act as a liaison between the Health Plan and the provider's office. Provider Relations Representatives can assist providers with contracting, training, policy and procedure questions, demographic updates, complaints, etc. To speak with your Provider Relations Representative please contact them directly or through our Provider Services Line at **1-877-653-0331**.

Long-Term Support Covered Services

At a minimum, Cigna-HealthSpring must provide all LTSS currently covered under the traditional, fee-for-service Medicaid program. The following is a non-exhaustive, listing of community-based, Long-Term Services and Supports included under Cigna-HealthSpring's Medicare-Medicaid Plan. Providers should refer to the Medicare-Medicaid Plan Handbook for a more inclusive listing of limitations and exclusions that apply to each benefit category. The Medicare-Medicaid Plan Handbook is available at:

<http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/index.html>.

Long-term Care Services Available to Medicare-Medicaid Plan Members

Personal Attendant Services (PAS) assist members with the performance of activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment. The level of assistance provided is determined by the member's functional needs and plan of care. Services may also include the provision of nursing tasks delegated by a registered nurse in accordance with state rules promulgated by the Texas Board of Nursing, and protective supervision provided solely to ensure the health and welfare of a member with cognitive/memory impairment and/or physical weakness. As discussed below, there are three (3) service delivery options: traditional agency option; Financial Management Services option; and Service Responsibility Option (SRO).

Medicare-Medicaid Plan members have a choice in service delivery options for Personal Attendant Services (PAS). They may use the:

- Traditional agency option
- Financial Management Services (FMS) option
- Service responsibility option (SRO)

The FMS option allows the member to serve as the employer and assume responsibility for screening, hiring, training and dismissing providers who provide PAS and/or in-home or out-of-home respite services. Those who elect to use the FMS option must select a Financial Management Services Agency (FMSA) to conduct financial management services such as payroll and employer taxes.

Cigna-HealthSpring contracts with FMS Agencies (FMSAs) and educates them regarding the service delivery options. In order to participate as a FMS provider for Cigna-HealthSpring, providers must be contracted with DADS as a FMSA and providers must attend the DADS FMSA training. Cigna-HealthSpring requires compliance with the Texas Administrative Code in Title 40, Part 1, Chapter 41, Sections 41.101, 41.103, and 41.105.

Day Activity and Health Services (DAHS) include nursing and personal care services, physical rehabilitation services, nutrition services, transportation services, and other supportive services in a day care environment that promotes socialization and decreases isolation. These services are offered by facilities licensed by the Texas Department of Human Services and certified by DAHS. Except for holidays, these facilities must have services available at least 10 hours a day, Monday to Friday.

HCBS Medicare-Medicaid Plan Nursing Facility Waiver Services Available to Members that Qualify

The HCBS Medicare-Medicaid Plan Facility Waiver Program, also known as the Medicare-Medicaid Plan Waiver Program, is an exception to Medicaid requirements. It is granted by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administering Medicare and

- > **Therapy Services** when a member has reached a maintenance level of care (chronic, no longer considered acute):
 - **Physical therapy** includes specialized techniques for the evaluation and treatment related to functions of the neuromusculo-skeletal systems. Services include the full range of activities provided by a physical therapist or a licensed physical therapy assistant under the direction of a licensed physical therapist, within the scope of the therapist's state licensure.
 - **Occupational therapy** includes interventions and procedures to promote or enhance safety and performance in instrumental activities of daily living, education, work, play, leisure and social participation. Services include the full range of activities provided by an occupational therapist or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, within the scope of the therapist's state licensure.
 - **Speech therapy** includes evaluation and treatment of impairments, disorders or deficiencies related to a member's speech and language. Services include the full range of activities provided by speech and language pathologists under the scope of their state licensure.
- > **Adult Foster Care:** Adult foster care is a 24-hour living arrangement in a DHS foster home for people who, because of physical or mental limitations, are unable to continue residing in their own homes. Services may include meal preparation, housekeeping, personal care, help with activities of daily living, supervision, and the provision or arrangement of transportation;
- > **Assisted Living:** Assisted living and residential care (AL/RC) is a twenty-four (24) hour living arrangement in a licensed personal care facility in which personal care, home management, escort, social and recreational activities, twenty-four (24) hour supervision, supervision of, assistance with, and direct administration of medications, and the provision or arrangement of transportation are provided. Under the HCBS Medicare-Medicaid Plan Waiver Program, personal care facilities may contract to provide services in three distinct types of living arrangements: (1) assisted living apartments, (2) residential care apartments, or (3) residential care non-apartment settings; and
- > **Transition Assistance Services (TAS):** Offers a maximum of \$2,500 to enhance the ability of nursing facility residents to transition and receive services in the community. TAS helps defray the costs associated with setting up a household for those members establishing an independent residence. When they are able to leave a nursing facility and return to the community TAS include, but are not limited to, payment of security deposits to lease an apartment, purchase of essential furnishings (table, eating utensils), payment of moving expenses, etc.
- > **Employment Assistance:** Employment Assistance Services is a service that assists individuals to obtain competitive integrate employment and includes, but are not limited to the following: Identifying a member's employment preferences, job skills, and requirements for a work setting and work conditions; locating prospective employers offering employment compatible with a member's identified preferences, skills, and requirements; and contacting a prospective employer on behalf of a member and negotiating employment.
- > **Supported Employment:** Supported Employment Services are assistive services provided in order to sustain paid employment, to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which members without disabilities are employed. Supported Employment includes employment adaptations, supervision, and training related to a member's diagnosis.
- > **Cognitive Rehabilitation Therapy:** Cognitive rehabilitation therapy is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.
- > **Financial Management Services:** These are services that help members using the Consumer Directed Services option to obtain Personal Attendant or other services in the home manage their payroll and budget.
- > **Support Consultation:** This service provides members with practical skills training and assistance to support consumer-directed services employers in areas such as recruiting, screening and hiring service providers.

Support consultation does not include budget, tax or workforce policy issues.

- > **Targeted Case Management:** Targeted Case Management (TCM) are services designed to assist members who are diagnosed with Severe and Persistent Mental Illness (SPMI) and Severe Emotional Disturbance (SED) with gaining access to needed medical, social, educational and other services and supports.
- > **Mental Health Rehabilitative Service:** Mental Health Rehabilitative Services are those age-appropriate services determined by HHSC and Federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness or serious emotional or behavioral disorders that help to increase the member's level of functioning and maintain independence in the home and the community. These services include the following: medication training and support, psychosocial rehabilitative services, skills training and development, crisis intervention, and day programming for acute episodes.
- > **Community First Choice (CFC)** allows Provider to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. All CFC services will be provided in a home or community based setting, which does not include a nursing facility, hospital providing long-term services, institution for mental disease, an intermediate care facility for individuals with an intellectual disability or related condition, or a setting with the characteristics of an institution. Community First Choice Services include: help with activities of daily living and health-related tasks through hands-on assistance, supervision or cueing; services to help the individual learn how to care for themselves; backup systems or ways to ensure continuity of services and supports; training on how to select, manage and dismiss attendants. CFC services include:
 - Personal Assistance Services
 - Emergency Response Services
 - Habilitation
 - Support Management

Lead Level Testing Results

Texas healthcare providers are required by law to report all lead level testing results for children and adults. The reporting forms and process are located on the Department of State Health Services website:

<http://www.dshs.state.tx.us/lead/providers.shtm>.

The regulatory requirements are available from these sources:

- > Texas Health and Safety Code, Chapter 88
<http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.88.htm>
- > Texas Administrative Code (Title 25, Part 1, Chapter 37, Rule §37.334)
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=37&sch=D&ri=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=37&sch=D&ri=Y)
- > Texas Health and Safety Code, Chapter 84, "Reporting of Occupational Conditions"
<http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.84.htm>
- > Texas Administrative Code (Title 25, Part 1, Chapter 99, Rule §99.1) [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=99&ri=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=99&ri=Y)

Pharmacy Prescription Benefit

Part D Drug Formulary

Formulary listings, utilization management criteria, and formulary changes for Cigna-HealthSpring formularies can be found at: <http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/drug-list.html>

Cigna-HealthSpring utilizes the USP classification system to develop Part D drug formularies that include drug categories and classes covering all disease states. Each category must include at least two drugs, unless only one drug is available for a particular category or class. Cigna-HealthSpring includes all or substantially all drugs in protected classes, as defined by CMS. All formularies are reviewed for clinical appropriateness by the national Cigna Pharmacy and Therapeutics (P&T) Committee, including the utilization management edits placed on formulary products. Cigna-HealthSpring submits all formulary changes to CMS according to the timelines designated by CMS.

A Part D drug is a drug that meets the following criteria: may be dispensed only by prescription; is approved by the FDA; is used and sold in the US; is used for a medically accepted indication; includes FDA-approved uses; includes uses approved for inclusion in the American Hospital Formulary Service Drug Information (AHFS DI), Micromedex, National Comprehensive Cancer Network (NCCN), Clinical Pharmacology, plus other authoritative compendia that the Secretary of Health and Human Services identifies, as off-label uses described in peer-reviewed literature are insufficient on their own to establish a medically accepted indication; and finally includes prescription drugs, biologic products, vaccines that are reasonable and necessary for the prevention of illness, insulin, and medical supplies associated with insulin that are not covered under Parts A or B (syringes, needles, alcohol, swabs, gauze, and insulin delivery systems).

Drugs excluded under Part D include the following: drugs for which payment as so prescribed or administered to an

individual is available for that individual under Part A or Part B; drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid (with the exception of smoking cessation products); drugs for anorexia, weight loss or weight gain; drugs to promote fertility; drugs for cosmetic purposes and hair growth; drugs for symptomatic relief of coughs and colds; vitamins and minerals (except for prenatal vitamins and fluoride preparations); nonprescription drugs; outpatient prescriptions for which manufacturers require the purchase of associated tests or monitoring services as a condition for getting the prescription (manufacturer tying arrangements); agents used for treatment of sexual or erectile dysfunction (ED) (except when prescribed for medically-accepted indications such as pulmonary hypertension).

Part D Utilization Management

Cigna-HealthSpring formularies include utilization management requirements that include prior authorization, step therapy and quantity limits.

- Prior Authorization (PA): For a select group of drugs, Cigna-HealthSpring requires the member or their physician to get approval for certain prescription drugs before the member is able to have the prescription covered at their pharmacy.
- Step Therapy (ST): For a select group of drugs, Cigna HealthSpring requires the member to first try certain drugs to treat their medical condition before covering another drug for that condition.
- Quantity Limits (QL): For a select group of drugs, Cigna-HealthSpring limits the amount of the drug that will be covered without prior approval.

The Centers for Medicare & Medicaid Services (CMS), in collaboration with the Pharmacy Quality Alliance (PQA), has identified certain medications as high risk when used in the elderly. This list is based upon the American Geriatrics Society (AGS) 2012 Updated Beers Criteria. All medications on the list are ones for which the AGS Expert Panel strongly recommends avoiding use of the medication in older adults. Use of these medications in the elderly may result in increased rates of adverse drug events, potential drug toxicity, and an increased risk of falls and/or fractures. Due to these safety concerns, Cigna-HealthSpring requires prior authorization for these medications in all members aged 65 and older in order to confirm that the benefits outweigh the risks, and that safer alternatives cannot be used.

Additional Demonstration Drugs

As part of the CarePlan pharmacy benefit, Cigna-HealthSpring will provide coverage under Medicaid for certain over the counter and Part D excluded medications. These medications can be identified on the plan formulary by the abbreviation "MC" listed in the right-hand column. Coverage will not be

provided for any over the counter product or Medicare Part D excluded drug that is not included on the formulary.

Medicare Part D Excluded Medications

Certain categories of medication are excluded from coverage under Medicare Part D. Any medication within one of these categories, except those over the counter medications specifically listed on the plan formulary, will be excluded from coverage under the pharmacy benefit for Medicare and Medicaid through Cigna-HealthSpring CarePlan. These categories include:

- Agents when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose (i.e., morbid obesity))
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or hair growth
- Agents when used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription drugs
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia

How to file a Coverage Determination

A Coverage Determination (CD) is any decision that is made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled. Coverage determinations may be received orally or in writing from the member's prescribing physicians. For the Provider Call center, please call **1-877-813-5595** or fax **1-866-845-7267**.

The address is:

Coverage Determination & Exceptions
PO Box 20002
Nashville, TN 37202

The Provider Call Center is open from 7am CST to 8pm CST Monday through Friday. Any call received after 8pm CST will be routed to a voicemail box and processed daily.

To ensure timely review of a CD and that the prescriber is aware of what Cigna-HealthSpring requires for the most commonly requested drugs, forms are available online at: <http://www.cigna.com/sites/careplantx/member-resources/forms/prior-auth.html> or by requesting a fax when calling **1-877-813-5595**.

A provider will receive the outcome of a Coverage Determination by fax no later than seventy-two (72) hours after receipt for standard requests or receipt of the supporting statement and no later than twenty-four (24) hours after receipt

for urgent requests or receipt of the supporting statement. The following information will be provided: 1) the specific reason for the denial taking into account the member's medical condition, disabilities and special language requirements, if any; 2) information regarding the right to appoint a representative to file an appeal on the member's behalf; and 3) a description of both the standard and expedited redetermination processes and timeframes including conditions for obtaining an expedited redetermination and the appeals process. The fax cover sheet includes the peer to peer process if a provider has questions and wants to review with a clinical pharmacist.

How to file a Part D Appeal

A Part D appeal can be filed within 60 calendar days after the date of the coverage determination decision, if unfavorable. Cigna-HealthSpring will ask for a statement and select medical records from the prescriber if a member requests a Part D appeal. For an expedited appeal, Cigna-HealthSpring will provide a decision no later than seventy-two (72) hours after receiving the appeal, and for a standard appeal, the timeframe is seven (7) days. If the request is regarding payment for a prescription drug the member already received, an expedited appeal is not permitted.

Part D Appeals may be received orally or in writing from the member's prescribing physicians by calling **1-866-845-6962** or fax **1-866-593-4482**.

The mailing address is:

**Part D Appeals,
PO Box 24207
Nashville, TN 37202-9910**

Pharmacy Quality Programs

Narcotic Case Management

Members with potential overutilization or inappropriate utilization of narcotics are identified based on approved criteria and reports are produced monthly. Members with at least three (3) controlled opioid pharmacy claims, three (3) different prescribers, three (3) different pharmacies and 120mg MED (morphine-equivalent dose) for 90 consecutive days within the reporting period of 120 days are included for case management. Any individual with cancer or on hospice care is excluded from the program. The Cigna-HealthSpring Clinical staff review claims data and determine whether further investigation with prescribers are warranted. If intervention is deemed appropriate, the case manager will send written notification to all prescribers by fax requesting information pertaining to the medical necessity of the current narcotic regimen. Cigna-HealthSpring will reach out to discuss the case and consensus must be reached by the prescribers if action is required. In the most severe cases, to assist with control of overutilization, point-of sale edits may be implemented if the prescriber desires.

Medication Therapy Management

Medication Therapy Management (MTM)-eligible members are offered a comprehensive medication review (CMR) annually. In the welcome letters sent to the eligible members, Cigna-HealthSpring encourages each member to call to complete their CMR before their annual comprehensive visit with their primary care provider so the member can take their medication list to the appointment. After the completion of the CMR, any potential drug therapy problems (DTPs) that are identified are sent to the prescribing provider and/or primary care provider by mail or fax. Along with DTPs, the provider also receives a list of the member's prescription history through the previous 6 months. If the member has any questions or comments about the DTP recommendations, a fax and phone number is provided for follow up. In addition to the CMR, providers may also receive targeted medication reviews (TMRs) quarterly. The TMRs are completed electronically to look for specific DTPs. If any DTPs are identified, a letter may be mailed or faxed to the provider.

Drug Utilization Review

Cigna-HealthSpring completes a monthly review of drug utilization data in order to determine the effectiveness, potential dangers and/or interactions of the medication(s). Retrospective Drug Utilization Review (rDUR) evaluates past data and Concurrent Drug Utilization Review (cDUR) ensures that a review of the prescribed drug therapy is performed before each prescription is dispensed, typically at the point-of-sale or point of distribution. Cigna-HealthSpring tracks and trends all drug utilization data on a regular basis to enable clinical staff to determine when some type of intervention may be warranted.

Targeted providers and/or members will receive information regarding quality initiatives by mail. Current Retrospective Drug Utilization Review (rDUR) studies that may be communicated to members or providers include:

- Overutilization of medications (≥10 drug prescriptions per month)
- Failure to refill prescribed medications
- Drug to drug interactions
- Therapeutic duplication of certain drug classes
- Narcotic safety including potential abuse or misuse
- Use of medications classified as High Risk for use in the older population
- Members with a probable diagnosis of Diabetes and Hypertension without a prescription for an ACE or ARB medication
- Use of multiple antidepressants, antipsychotics, or insomnia agents concurrently
- Multiple prescribers of the same class of psychotropic drug

- Underutilization of certain drug classes as determined by failure to meet a PDC (Proportion of days covered) $\geq 80\%$.

Letters to members will focus on the rationale for medication adherence and/or the safety issues involved. Letters to providers will include the rationale of the particular concern being addressed and will include all claims data for the selected calendar period applicable to that initiative. From any initiative, if a provider indicates that they did not write a prescription that has been associated with them or that they were not providing care for the member at the time the prescription under investigation was written please notify Cigna-HealthSpring using the contact information on the letter.

A multidisciplinary team develops and determines the direction of pharmacy quality initiatives and the initiatives come from a variety of sources, including but not limited to, claims data analysis, Centers for Medicare and Medicaid Services (CMS) guidance, Pharmacy Quality Alliance (PQA), Food and Drug Administration (FDA) notifications, drug studies, and publications.

Cigna Home Delivery Pharmacy

One of the most important ways to improve the health of your patients is to make sure they receive and take their medications as you prescribe. Cigna Home Delivery Pharmacy can help. Our members have 20% higher adherence rates when compared to those who use retail pharmacies alone. We send a three month supply in one fill making it easier for your patient by only having to fill four times a year. Lastly, our members have access to our QuickFill service which sends automatic reminders via email, phone or SMS text message making it easier for patients to refill their prescriptions so they don't miss a dose. Talk to your patients today about Cigna Home Delivery Pharmacy for better health and health care spending. Doctors and staff can reach us at **1-800-285-4812** (option 3) or fax prescriptions to **1-800-973-7150**.

Value-Added Services

Medicare-Medicaid Plan MMP offers extra services in addition to Medicare and Medicaid services, and cannot be used in place of Medicare or Medicaid services. These benefits have been added to Cigna-HealthSpring's Medicare-Medicaid Plan (MMP) in order to promote healthy lifestyles and improve health outcomes for members.

Initially, Cigna-HealthSpring notifies new members in the Welcome Kit regarding the available value-added services and how to access them. Thereafter, Cigna-HealthSpring sends benefit education materials to members annually, outlining the available value-added services and how to access them. Additional details about value-added services are available at <http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/index.html>. Cigna-HealthSpring members can get assistance accessing value-added services from their Service Coordinator by calling **1-877-725-2688** or by calling Member Service at **1-877-653-0327**. Cigna-HealthSpring's Value-Added Services are listed in the chart on the following pages:

| Value Added Service | Contact Information | Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in a Nursing Facility | Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in the Community |
|-----------------------------|---|--|--|
| 24- Health Information Line | 1-855-418-4552 | Yes | Yes |
| Extra Help Getting a Ride | Cigna-HealthSpring Member Service Department 1-877-653-0327 | Unlimited round trip transportation provided for plan-approved locations when other transportation cannot be accessed. | <ul style="list-style-type: none"> ➤ Help getting a ride to doctor visits ➤ Unlimited round trip transportation provided for plan-approved locations when other transportation cannot be accessed. |

| Value Added Service | Contact Information | Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in a Nursing Facility | Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in the Community |
|---|---|--|--|
| Extra Dental Services for Adults (age 21 and older) | DentaQuest -Providers: 1-888-308-9345 DentaQuest -Members: 1-855-418-1628 | <ul style="list-style-type: none"> > One preventive dental oral exam every 6 months for non-Medicare-Medicaid Plan Waiver (SPW) Members > One preventive dental-prophylaxis (cleaning) every 6 months for non-Medicare-Medicaid Plan Waiver (SPW) Members > One Preventive Dental Bitewing X-ray every year for non-Medicare-Medicaid Plan Waiver (SPW) Members > One full mouth & panoramic X-ray every 36 months for non-Medicare-Medicaid Plan Waiver (SPW) Members | <ul style="list-style-type: none"> > One preventive dental oral exam every 6 months for non-Medicare-Medicaid Plan Waiver (SPW) Members > One preventive dental-prophylaxis (cleaning) every 6 months for non-Medicare-Medicaid Plan Waiver (SPW) Members > One Preventive Dental Bitewing X-ray every year for non-Medicare-Medicaid Plan Waiver (SPW) Members > One full mouth & panoramic X-ray every 36 months for non-Medicare-Medicaid Plan Waiver (SPW) Members |
| Extra Vision Services | Superior Vision 1-800-879-6901 Cigna-HealthSpring Member Service Department 1-877-653-0327 | <ul style="list-style-type: none"> > One routine eye exam every two years > Contact Lenses or Eyeglasses (Lenses and Frames) every two years | <ul style="list-style-type: none"> > One routine eye exam every two years > Contact Lenses or Eyeglasses (Lenses and Frames) every two years |
| Hearing Services | Cigna-HealthSpring Member Service Department 1-877-653-0327 | <ul style="list-style-type: none"> > Unlimited routine hearing exam > One fitting/evaluation for a hearing aid per exam > One hearing aid (left or right ear) every five years | <ul style="list-style-type: none"> > Unlimited routine hearing exam > One fitting/evaluation for a hearing aid per exam > One hearing aid (left or right ear) every five years |
| Drug Store Services | Cigna-HealthSpring Member Service Department 1-877-653-0327 | \$20 of OTC items covered every month \$20 of OTC items covered every month (Note: \$20 limit does not apply to formulary OTC medications found on the Additional Demonstration Drug list) | \$20 of OTC items covered every month (Note: \$20 limit does not apply to formulary OTC medications found on the Additional Demonstration Drug list) |
| Home Visits | Cigna-HealthSpring Service Coordination 1-877-725-2688 | N/A | 8 hours of respite care one time each year for non- Medicare-Medicaid Plan Waiver (SPW) Members |
| Extra Help for Pregnant Women | Cigna-HealthSpring Service Coordination 1-877-725-2688 | Book for expecting moms | Book for expecting moms |

| Value Added Service | Contact Information | Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in a Nursing Facility | Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Members in the Community |
|-----------------------------------|---|--|--|
| Emergency Response Services (ERS) | Cigna-HealthSpring Service Coordination 1-877-725-2688 | N/A | Emergency Response System access in member's home for rapid response to medical emergencies for non- HCBS Medicare-Medicaid Plan (SPW) Waiver members |
| Health and Wellness Services | Cigna-HealthSpring Service Coordination 1-877-725-2688 | <ul style="list-style-type: none"> > Active & Fit Home Fitness Kit or Facility Membership for members > Tobacco Cessation Program for eligible non-Medicare-Medicaid Plan Waiver (SPW) members | <ul style="list-style-type: none"> > Active & Fit Home Fitness Kit or Facility Membership for members > Ten (10) home-delivered meals one (1) time after getting out of the hospital > Tobacco Cessation Program for eligible non-Medicare-Medicaid Plan Waiver (SPW) members |
| Gift Programs | Cigna-HealthSpring Member Service Department 1-877-653-0327 | <ul style="list-style-type: none"> > One cold and flu kit per member each year > One personal hygiene kit per member each year > Clip-on lamp > Fleece Blanket > Reacher/Grabber | <ul style="list-style-type: none"> > One cold and flu kit per members each year > One A.M./P.M. 7-day Pillbox each year for members for non-Medicare-Medicaid Plan Waiver (SPW) members > One box of vinyl gloves each month for members for eligible non-Medicare-Medicaid Plan Waiver (SPW) members > One first aid kit per member each year > Clip-on lamp > Fleece Blanket > Reacher/Grabber |

Non-Medicaid Managed Care Covered Services (Non-Capitated Services)

Non-Medicaid Managed Care Covered Services, or Non-Capitated Services, are services that are covered benefits under the STAR+PLUS program, but they are excluded from HHSC's payments to STAR+PLUS HMOs. Instead of being managed and paid for by the HMOs, Non-Capitated Services are paid through HHSC's Administrative Contractor. This includes things like transportation, immunizations, and hospice services. Even though Cigna-HealthSpring does not pay claims for these services directly, Cigna-HealthSpring coordinates these essential components of the Member's benefit package. By integrating Non-Capitated Services with physical, behavioral, and long term support services, Cigna-

HealthSpring can offer a full complement of medically necessary services and achieve optimal care coordination. Non-Capitated Services include the following:

- > Department of State Health Services (DSHS) Case Management for Children and Pregnant Women;
- > Texas School Health And Related Services (SHARS);
- > Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
- > Tuberculosis (TB) Services Provided by DSHS-Approved providers (directly observed therapy and contact investigation);
- > Health and Human Services Commission's Medical Transportation Program (MTP);

- > Summary of MTP services and phone numbers for both MTP and FRBs
- > FRB – Specific service areas
- > Department of Aging and Disability Services (DADS) hospice services;
- > Admissions to inpatient mental health facilities as a condition of probation if stay is not medically necessary
- > PASRR screenings, evaluations, and specialized services
- > For STAR+PLUS, Nursing Facility services (non-capitated until February 28, 2015)
- > DADS contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities.
- > DADS contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities
- > Department of State Health Services (DSHS) Targeted Case Management (non-capitated service coordinated by LMHAs until August 31, 2014)
- > DSHS Mental health rehabilitation (non-capitated until August 31, 2014)

- > Attendant services (a responsible adult who accompanies a minor or an attendant needed for mobility assistance or due to medical necessity, who accompanies the client to a healthcare service)
- > Advanced funds to cover authorized transportation services prior to travel

Call MTP: For more information about services offered by MTP, clients, advocates and providers can call the toll free line at **1-877-633-8747**. In order to be transferred to the appropriate transportation provider, clients are asked to have either their Medicaid ID# or zip code available at the time of the call. For transportation services within the county where the member lives, he/she should call at least two (2) business days before the scheduled appointment. For transportation services outside the county in which the member lives, he/she should call at least five (5) business days before the scheduled appointment. **For any transportation needs or questions beyond what MTP can provide, the member should call the Service Coordination line for assistance.**

EMERGENCY SERVICES

Definitions

The following are definitions for routine, urgent, and emergent care:

- > **Routine care:** Routine care means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.
- > **Urgent Condition:** Urgent condition means a health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four (24) hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health.
- > **Emergency Services:** Emergency Services are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services. Emergency care is covered for Cigna-HealthSpring members twenty-four (24) hours a day, seven (7) days a week. Prior authorization is not required for Emergency Services.

Emergency Behavioral Health Condition

Emergency Behavioral Health means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing

Medical Transportation Program (MTP)

What is MTP?

MTP is a state administered program that provides Non-Emergency Medical Transportation (NEMT) services statewide for eligible Medicaid clients who have no other means of transportation to attend their covered healthcare appointments. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?

- > Passes or tickets for transportation such as mass transit within and between cities or states, to include rail, bus, or commercial air
- > Curb to curb service provided by taxi, wheelchair van, and other transportation vehicles
- > Mileage reimbursement for a registered individual transportation participant (ITP) to a covered healthcare event. The ITP can be the responsible party, family member, friend, neighbor, or client.
- > Meals and lodging allowance when treatment requires an overnight stay outside the county of residence

an average knowledge of health and medicine: (1) requires immediate intervention and/or medical attention without which members would present an immediate danger to themselves or others, or (2) which renders members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Medical Condition

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Except for Emergency Services, members are encouraged to contact their PCP prior to seeking care. In the case of an Emergency Medical Condition, a Cigna-HealthSpring member may access care at any provider office or hospital. Members should contact Cigna-HealthSpring or their PCP by the close of the next business day to notify Cigna-HealthSpring of the Emergency Medical Condition.

Emergency Prescription Supply

A seventy-two (72) hour emergency supply of a prescribed drug must be provided when medication is needed without delay and prior authorization is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List (PDL) or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Cigna-HealthSpring or Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

Call OptumRx at **1-844-265-1770** for more information about the 72-hour emergency prescription supply policy.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- Place an "8" in "Prior Authorization Type Code" (Field 461-EU).
- Ensure that "801" is in "Prior Authorization Number Submitted" (Field 462-EV).

- Also be sure a "3" is in "Days Supply" (in the Claim segment of the billing transaction) (Field 405-D5).
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber.
- If the medication is a dosage form that prevents a three-day supply from being dispensed (e.g. an inhaler, eye or ear drops, or creams) it is permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispensed.

Please note, the 72-hour emergency supply is only available for Medicaid-covered medications and does not apply Medicare Part D covered prescriptions or other Medicare Part D excluded medications.

Requirements for Early Refills of Certain Drugs

Members must exhaust 75% of the prescribed medication before a pharmacy may refill a prescription or fill a new prescription for the same drug.

Emergency Transportation

When a member has an Emergency Medical Condition as defined above, emergency transportation is covered at the basic life support (BLS) level. Prior authorization from Cigna-HealthSpring is not required for emergency transportation. Facility-to-facility transport may be considered an emergency if the emergency treatment is not available at the first facility and the member still requires Emergency Services.

Emergency Dental Services

Cigna-HealthSpring is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- Treatment of oral abscess of tooth or gum origin.

Under some circumstances, non-emergent dental services may be covered under STAR+PLUS benefits.

Non-Emergent Ambulance Transportation

Non-emergent ambulance transportation is a covered benefit in the Medicaid program for members who are severely disabled or have limited mobility.

All non-emergent, ambulance transportation requires prior authorization from Cigna-HealthSpring. For more information about obtaining prior authorization, providers should reference the Medical Management section of this provider manual.

Non-Emergency Dental Services

Medicaid Non-emergency Dental Services:

Cigna-HealthSpring is not responsible for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.

Cigna-HealthSpring is responsible for paying for treatment and devices for craniofacial anomalies and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members aged 6 through 35 months.

OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist Members with establishing a Main Dental Home and document Member's Main Dental Home choice in the Members' file.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Cigna-HealthSpring reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified Members, this includes medically necessary items such as nebulizers, ostomy supplies or bedpans, and other supplies and equipment. For children (birth through age 20), Cigna-HealthSpring also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products. Cigna-HealthSpring may require an authorization for items not typically covered. The Provider will need to verify with Provider Services at 1-877-653-0331 for information regarding non-covered services.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must hold a separate ancillary contract with Cigna-HealthSpring, to cover reimbursement for DME products and be credentialed with Cigna-HealthSpring; separate from the pharmacy's credentialing status with Cigna-HealthSpring's pharmacy benefit manager. Participating pharmacies may bill

us in accordance with claims filing guidelines in the Billing and Claims Administration section of this manual.

Call Cigna-HealthSpring's Provider Services at 1-877-653-0331 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

MEDICARE-MEDICAID PLAN ELIGIBILITY & ENROLLMENT

Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Eligibility

CMS and HHSC shall have sole responsibility for determining the eligibility of an Enrollee for a Medicare-Medicaid Plan. The Enrollee will be required to meet all criteria below: People age 21 or older and

- Get Medicare Part A, B and D, and are receiving full Medicaid benefits
- Eligible for or enrolled in the Medicaid STAR+PLUS program, which serves members who have disabilities and those who meet a nursing facility level of care and get STAR+PLUS home and community based waiver services

Certain Medicaid clients are excluded from enrolling in a Medicare-Medicaid Plan. This includes:

- Individuals under the age of 21
- Individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions (ICF/IIDs)
- Individuals receiving services through the following section 1915(c) waivers will be excluded from the demonstration
- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities Program (DBMD)
- Home and Community-based Services (HSC)
- Texas Home Living Program (TxHmL)

Enrollment

Once a Medicaid client is determined by CMS and HHSC to be eligible for a Medicare-Medicaid Plan, he/she will receive letter in the mail from HHSC's administrative services contractor, MAXIMUS. The letter contains information about the Medicare-Medicaid Plan, instructions for remaining with the Medicare-Medicaid Plan chosen for them, changing plans or opting-out of the demonstration. MAXIMUS processes Medicare-Medicaid Plan applications, assists members who are transitioning from traditional, fee-for-service Medicare or Medicaid into the Medicare-Medicaid Plan and assists members in selecting an

MCO and a PCP. Members who need assistance can contact an enrollment counselor by calling the MAXIMUS Helpline at **1-800-782-6440**.

Because Medicare-Medicaid Plan members may change health plans, lose Medicaid eligibility, or change PCPs routinely, it is crucial for providers to verify member eligibility prior to rendering services. If a provider does not verify eligibility prior to rendering services and the member is determined later not to be a Cigna-HealthSpring member, then Cigna-HealthSpring cannot reimburse the provider for his/her services. Eligibility verification prior to every visit is essential to ensuring providers receive payment for services rendered. It is recommended to verify eligibility every first of the month since members can switch health plans every month.

Verifying Eligibility

Eligibility can be verified in a variety of different ways: through member identification cards, through Cigna-HealthSpring's Provider Portal at <https://starplus.hsconnectonline.com> or telephone verification process, or through State sources such as the Automated Inquiry System (AIS) and TexasMedConnect.

Cigna-HealthSpring Member Identification Cards

Cigna-HealthSpring issues an identification card (ID) to all members no later than the last calendar day of the month prior to the effective date of coverage. This card identifies the member as a Cigna-HealthSpring member. Also, it gives providers quick access to important information such as the member's name and identification number, the PCP's name and phone number, the Cigna-HealthSpring claims filing address, and the phone number for prior authorizations and member Services. Providers should ask members to present this ID card at the time of service. An example of the Cigna-HealthSpring ID card is provided in Appendices of this provider manual.

The Texas Benefits Medicaid Card and Form 1027-A (Temporary Medicaid Identification)

In addition to a Cigna-HealthSpring ID card, all members should have a Texas Benefits Medicaid Card from the Texas Department of Human Services or a Form 1027-A (Temporary Medicaid Identification Form). The Texas Benefits Medicaid Card indicates a member's eligibility dates, and the member's Medicaid identification number. Form 1027-A is a Temporary Medicaid Identification Form and it is issued prior to issuance of a Texas Benefits Medicaid Card. When a member presents for services, providers should make a copy of all identification cards and keep them on file. An example of the Texas Benefits Medicaid Card and Form 1027-A are provided in Appendices of this provider manual.

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the dates of

service prior to the service being rendered. There are several ways to do this:

- Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology
- Use TexMedConnect on the TMHP website at www.tmhp.com
- Call the Your Texas Benefits provider helpline at **1-855-827-3747**
- Call Provider Services at the patient's medical or dental plan
- Search for the patient using www.YourTexasBenefitsCard.com, a secure website with a variety of useful features for Medicaid providers

Important: Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling 1-855-827-3748. Medicaid members also can go online to order new cards or print temporary cards.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. A copy is required during the appeal process if the client's eligibility becomes an issue.

Your Texas Benefits gives providers access to Medicaid health information. Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the 'Initial Registration Guide for Medicaid Providers'. For more information on how to get registered, download the 'Welcome Packet' on the home page.

YourTexasBenefitsCard.com allows providers to:

- View available health information such as:
 - Vaccinations
 - Prescription drugs
 - Past Medicaid visits
 - Health Events, including diagnosis treatment and,
 - Lab results
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Use the Blue Button to request a Medicaid patient's available health information in a consolidated format.

Patients can also log in to www.YourTexasBenefits.com to see their benefit and case information; print or order a Medicaid ID card; set up Texas Health Steps Alerts; and more. If you have questions, call 1-855-827-3747 or email ytc-card-support@hpe.com.

Telephonic and Electronic Eligibility Verification

- Once the provider has made a copy of the member's identification cards, the next step is to verify eligibility telephonically or electronically. As mentioned previously, members can change PCPs anytime and change MCOs monthly resulting in member identification cards being outdated almost as soon as they are printed. Telephonic and electronic verification give providers access to "real time" eligibility information and provide another level of assurance that the provider's claim can be processed quickly.

Verifying Eligibility through Cigna-HealthSpring

Providers can call Cigna-HealthSpring at **1-877-653-0331**, Monday to Friday, 8 a.m. to 5 p.m. Central Time, to speak with a representative who can verify eligibility or they can use Cigna-HealthSpring's Automated Eligibility Verification Line by calling **1-866-467-3126**; this system is available twenty-four (24) hours a day, seven (7) days a week. A third option for verifying eligibility through Cigna-HealthSpring is through the Provider Portal at <https://starplus.hsconnectonline.com>.

Verifying Eligibility through State Resources

There are two key, State resources for verifying eligibility. These are the Automated Inquiry System (AIS) and TexMedConnect. AIS are available twenty-three (23) hours per day, seven (7) days per week. The system can be reached by calling **1-800-925-9126**. TexMedConnect is a free, web-based application provided by TMHP. To submit an eligibility inquiry, the user must enter the member identification number, date of birth, and social security number. Eligibility inquiries can be made twenty-four (24) hours per day, seven (7) days per week. To enroll in the TexMedConnect program, providers can contact TMHP or visit their website at <http://www.tmhp.com>.

Monthly PCP Panel Reports

On a monthly basis, Cigna-HealthSpring supplies each PCP with a member panel report. The report contains a listing of all members assigned to the PCP's member panel and is sent to PCPs within five (5) days of receiving State eligibility files. The PCP is responsible for providing and/or coordinating care for the all members on the report according to the requirements outlined in this provider manual and the Cigna-HealthSpring participating provider agreement.

PCPs may access their panel report online at. If a member does not appear on the PCP's panel report, the PCP can call the Cigna-HealthSpring Provider Services Department at 1-877-653-0331 to verify the member's PCP assignment.

Disenrollment

Member disenrollment from Cigna-HealthSpring may occur if the member:

- Selects another Medicare-Medicaid Plan
- Decides to Opt-out of the Demonstration
- Moves out of the Service Area for more than six (6) months
- Is determined to have Third-Party Coverage
- Is incarcerated
- Is no longer eligible for MMP

A member may request a disenrollment through the HHSC Administrative Services Contractor. If the member contacts Cigna-HealthSpring to request a disenrollment, Cigna-HealthSpring will direct the member to contact the MAXIMUS Helpline at **1-800-782-6440**.

Any time an individual requests to Opt-Out of Passive Enrollment or disenrolls from the Medicare-Medicaid Plan, the State or the Administrative Services Contractor will send a letter confirming the Opt-Out and disenrollment effective date in addition to providing information on the Medicaid benefits available to the beneficiary once they have opted out or disenrolled, and contact information to receive more information about Medicare benefits. If a member requests a voluntary disenrollment it will be processed as a complaint through Cigna-HealthSpring's complaint process.

Cigna-HealthSpring has a limited right to request involuntary member disenrollment

Additionally, Cigna-HealthSpring may request involuntary disenrollment when there is evidence of member non-compliance such as:

- The member misuses or loans his/her identification card to another person to obtain services
- The member is disruptive, unruly, threatening or uncooperative to the extent that his/her membership seriously impairs Cigna-HealthSpring's or the provider's ability to provide services to the member or to obtain new members and the aforementioned behavior is not caused by a physical or behavioral health condition
- The member is steadfastly refusing to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the MCO to coordinate treatment of the underlying medical condition)

If a provider identifies a non-compliant member, the provider should call the Cigna-HealthSpring Provider Services Department at **1-877-653-0331** to report the concern. Cigna-HealthSpring will research the concern and decide if the

situation warrants requesting an involuntary disenrollment through HHSC. Cigna-HealthSpring will document all attempts by the provider and Cigna-HealthSpring to rectify the situation. This may include member education and counseling. Then, Cigna-HealthSpring will submit the documentation to HHSC for review. HHSC's Disenrollment Committee will review the disenrollment request. Within five (5) business days of receipt of all information necessary to complete the review, the Disenrollment Committee will make a final determination regarding the disenrollment request. HHSC will provide the member notice of its determination which will include information about the Appeal and Fair Hearing process. Cigna-HealthSpring cannot request a disenrollment based on adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition. Additionally, a provider cannot take retaliatory action against a member who is disenrolled from Cigna-HealthSpring. HHSC will make the final decision on any involuntary disenrollment request by Cigna-HealthSpring.

Span of Eligibility

Members can change HMOs by calling the Maximus Helpline at **1-800-782-6440**. Members cannot change health plans while they are in the hospital as a patient.

If a member calls to change health plans on or before the 12th of the month, the change will take place on the first day of the next month. If he/she calls after the 12th of the month, the change will take place the first day of the second month after that. For example:

- > If the member asks to change plans on or before April 12, the change will take place on May 1
- > If the member asks to change plans after April 12, the change will take place on June 1

Members can change PCPs at any time by calling the Cigna-HealthSpring Member Services Department at **1-877-653-0327**. PCP changes are effective on the next business day, following a member request.

Automatic Re-Enrollment

Members disenrolled due to temporary ineligibility for Medicaid will be automatically re-enrolled with their previously selected HMO and PCP when they regain eligibility status. Temporary loss of eligibility is defined as a loss of eligibility for a period of six (6) months or fewer. Members can opt to change HMOs at the time of automatic re-enrollment or at any other time through MAXIMUS by calling the Medicaid Managed Care Helpline at 1-800-964-2777.

Retroactive Eligibility Changes

Member eligibility is subject to retroactive changes for various reasons. If a member's eligibility in Cigna-HealthSpring is retroactively terminated, the Cigna-HealthSpring Claim Recovery Department will request a refund for all previously

paid claims from the provider. It is the provider's responsibility to re-verify eligibility to determine the Member's coverage for the date(s) of service in question and then file the claim with the appropriate payer.

Service Coordination and Disease Management

Through a specialized care management service called Service Coordination, Cigna-HealthSpring ensures that members are aware of all services that are available to them and that members have a central role in planning and directing their own health care. Service coordination includes:

- > Identification of needs, including physical health, mental health services and LTSS
- > Development of a service plan to address identified needs
- > Assistance to ensure timely and coordinated access to providers and covered services
- > Attention to addressing unique member needs

Additionally, the Service Coordinator assists members in accessing social services and other community resources, and other medical services that are not part of the covered benefit set, and are delivered outside of Cigna-HealthSpring, such as:

- > Texas agency administered programs and case management services
- > Essential public health services
- > Texas Commission for the Blind case management
- > Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- > Medical transportation services available through the Texas Health and Human Services Commission
- > Hospice services

Service Coordinator Assignments

Service Coordinators are assigned based on members' Long-Term Services and Supports (LTSS) and disease management needs. Members are assigned to a Service Coordinator according to the table below. In addition, Cigna-HealthSpring provides a Service Coordinator to any Medicare-Medicaid Plan member who requests one, including members who are not currently receiving HCBS Medicare-Medicaid Plan Waiver Program services.

| Member Needs | LTSS Assignment |
|---|--|
| HCBS Medicare-Medicaid Plan Waiver Program Members OR COMPLEX MEDICAL NEEDS | Licensed RN nurse |
| Members with LTSS services and complex Behavioral Health Members | Licensed LVN nurse or licensed social worker |

| Member Needs | LTSS Assignment |
|--|---|
| Members in ICF/IID, CLASS, DBMD, HCS and TxHmL Waiver Programs | Licensed RN or LVN nurse or licensed social worker |
| Medicare-Medicaid Plan Members not identified in the above categories. | Licensed LVN nurse or licensed social worker |
| Members with significant behavioral health needs | Qualified behavioral health specialist in addition to the Service Coordinator |

- > A summary of current medical and social needs and concerns
- > Short and long term needs and goals
- > A list of services required and the frequency of such services
- > A description of who will provide each service

Also, the SP/ISP may include information for Non-Capitated Services such as how to access affordable, integrated housing or other community resources. Members or their Authorized Representative sign the ISP to indicate their agreement with the services listed.

Authorization of Services through the Service Coordinator

Once a care plan is established, the Service Coordinator works with the member's PCP to authorize services, including referrals to Specialty Care Providers. If a Specialty Care Provider will be delivering care on an on-going basis, a standing referral is established. At the member's discretion and with the Specialty Care Provider's approval, the Specialty Care Provider may be designated as the member's PCP. Authorization for office visits to the PCP or in network Specialists is not required. Prior to rendering additional services beyond routine office care, providers should contact the Service Coordinator to ensure that services are authorized appropriately. Providers and members can reach the Cigna-HealthSpring Service Coordination Department by dialing **1-877-725-2688** or by fax at **1-877-809-0789**.

Disease Management (DM)

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

The DM program includes the regular assessment of:

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

The Service Coordination team is the primary point of contact for providers when there are issues or questions about a member. As such, providers should contact the Service Coordinator whenever there are changes in a member's health status. When a member's Service Coordinator changes as a result of membership changes or as the needs of members evolve, Cigna-HealthSpring provides written notice to the member within 10 business days. Providers may obtain the name of any member's assigned Service Coordinator by accessing this information on the Provider Portal.

Cigna-HealthSpring has administrative staff members who assist the Service Coordinators, but they are not responsible for Service Coordination functions. Their roles are restricted to non-clinical, administrative, and workflow tasks, such as telephone calls, correspondence, and record keeping.

Long-Term Services and Supports

Cigna-HealthSpring ensures that members receive medically necessary Long-Term Services and Supports (LTSS) services promptly. Members receiving HCBS Waiver Program services, Personal Attendant Services (PAS), and Day Activity Health Services (DAHS) are assessed within thirty (30) days of enrollment, and annually thereafter. Annual assessments are completed within ninety (90) days prior to the Member's enrollment anniversary. Cigna-HealthSpring works with each Member, sharing which Service Coordinator they are assigned to and the number of assessments they can expect to receive yearly. Additionally, Cigna-HealthSpring conducts needs-based assessments when there are material changes in a member's clinical condition, hospitalization or personal circumstances. Cigna-HealthSpring uses assessment instruments from the Texas Department of Aging and Disability Services to conduct member assessments. Assessment results are used to develop a care plan which is called a Service Plan (SP) or an Individual Service Plan (ISP). The SP/ISP is a seamless plan of care which includes primary care, acute care, and long-term care services in a single, comprehensive plan. It promotes consumer direction and self-determination and includes:

- > The member's physical and behavioral health history

- > Interdisciplinary care team meetings where the provider is a valued participant

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

Care and Service Plans (CSPs)

Each Medicare-Medicaid Plan member served by Cigna-HealthSpring has a single Care and Service Plan (CSP). The CSP combines the ISP and the DM care plan, and addresses each member's unique LTSS, DM and behavioral health needs. It contains all assessment outcomes, Service Coordinator and utilization management notes, authorizations, and any available claims and diagnostic data. Cigna-HealthSpring's policy is to use all reasonable efforts to limit access to members' Personal Health Information to the minimum necessary required to complete a task.

Discharge Planning

The Texas Department of Health And Human Services (HHSC) requires that Cigna-HealthSpring and its providers comply with quality measures published in the Texas Uniform Managed Care Manual as well as generally accepted standards governing safe hospital discharge.

Completed discharge instructions as shown to the member must be faxed to Cigna-HealthSpring at the time of discharge to fax number **1-877-809-0786** or **1-855-500-2806** for Behavioral Health. Please see Medical Management/Utilization Management Section.

Service Coordination and Utilization Management staff collaborates with the inpatient provider to ensure that all services needed by the member at discharge are in place to allow for a smooth transition from hospital back to the community. Service Coordination staff, Behavioral Health Case Managers or Disease Management staff follow up with the member within 3 days of discharge to ensure that all needs are being met and arrange for any additional services that member needs to continue recuperating and to avoid readmission.

Transition Plan

A PCP can request that a member be moved to another PCP for non-compliance with treatment recommendations or threatening behavior. Other reasons may include, but are not limited to:

- > Member often misses office visits without calling
- > Member does not follow your advice
- > Member is disruptive to your practice

All requests will be reviewed by Cigna-HealthSpring on a case by case basis. The member will be notified in

writing within ten days of the decision and asked to call Cigna-HealthSpring Member Service to select a new PCP. If the member does not select a new PCP, Cigna-HealthSpring will assign a new PCP to them and notify them of the change.

Coordination with Other Agency Providers

All Home and Community Support Services Agency (HCSSA) providers and adult day care providers must notify Cigna-HealthSpring if a member experiences any of the following:

- > A significant change in the member's physical or mental condition or environment
- > Hospitalization
- > An emergency room visit
- > Two or more missed appointments
- > Member away for an extended period of time (7 days or more) such that services and billing will be interrupted

UTILIZATION MANAGEMENT

Cigna-HealthSpring is certified by the State of Texas as a Utilization Review Agent (URA) to perform medical management functions for members enrolled in the Cigna-HealthSpring Medicare-Medicaid Plan. Cigna-HealthSpring coordinates physical and behavioral health services to ensure quality, timely, clinically-appropriate, and cost-effective care that results in clinically desirable outcomes. Cigna-HealthSpring's goal is to improve members' health and well-being through effective ambulatory management of chronic conditions, resulting in a reduction of avoidable inpatient admissions. The Utilization Management (UM) process provides an opportunity for Cigna-HealthSpring to:

- > Determine the medical necessity and appropriateness of the services
- > Ensure that services are provided at the most appropriate level of care
- > Ensure the services are provided by the most appropriate provider and in the most appropriate setting
- > Ensure that services are covered under the member's benefit plan
- > Monitor participating providers' practice patterns
- > Improve utilization of resources by identifying and correcting patterns of over or under utilization
- > Identify high-risk members
- > Provide utilization data for use in the re-credentialing process.

Utilization Review Criteria

Utilization review decisions are made in accordance with currently accepted medical or health care practices, taking into account the special circumstances of each case that may require deviation from the norm as stated in the screening criteria. Cigna-HealthSpring utilizes InterQual criteria for approving medically necessary physical and behavioral health services. At least annually, Cigna-HealthSpring assesses the consistency with which reviewers apply the criteria. Criteria are available for review and inspection by the Texas Department of Insurance Commissioner or designated representative and, upon written request for a specific case, to individual providers.

All medical necessity denials of health care services requested by a member are reviewed by the Medical Director. Only a Medical Director has the authority to render adverse determinations for medical necessity requests. Special circumstances include, but are not limited to, a person with a disability, acute condition, or life-threatening illness.

Utilization review decision-making is based only on medical necessity and appropriateness of care and service. Cigna-HealthSpring's compensation to providers, associates, or other individuals conducting utilization review on its behalf does not contain incentives, direct or indirect, to approve or deny payment for the delivery of any health care service.

Authorization Process

Cigna-HealthSpring encourages members to access care through their PCPs first. If the PCP determines that specialty care, diagnostic testing, or other ancillary services are required, the PCP should refer the member to an in-network provider. Cigna-HealthSpring does not require prior authorization for a member to have an office visit with an in-network provider. Under Medicare-Medicaid Plan referrals are not required. A Specialist may require a referral from the PCP, but Cigna-HealthSpring does not require one. Request for authorization are required for items on the Appendices of this provider manual. In the Appendices is Cigna-HealthSpring's list of Prior Authorization Services. This list is also referenced on the provider tab on Cigna-HealthSpring's website at: <http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/index.html>. The list of Prior Authorization Services is intended to provide an overview of services requiring authorization. If a member requires a service that is not listed in the Appendices, the provider may contact Health Services to inquire about the need for prior authorization. The presence or absence of a procedure or service on the list does not determine a member's coverage or benefits. Authorization is not a guarantee of payment.

Prior Authorization (services that have not been rendered)

To initiate the prior authorization process, providers should follow the procedures listed below. The provider evaluates a Cigna-HealthSpring member and determines that a "prior

authorization service" is required according to the Authorization Requirement List. At least five (5) business days prior to the requested date of service, the provider completes a Prior Authorization Request Form which is found in the Appendices of this provider manual. The provider should include all pertinent clinical information supporting the need for the requested service such as symptoms, results of any diagnostic tests or laboratory services results and treatment plan. After receipt of a request for service authorization, Cigna-HealthSpring reviews the clinical presented. If the clinical is insufficient to make a clinical determination, more information is requested based on InterQual criteria. Three attempts are made to obtain clinical information either by phone/fax or both with the provider. The required turnaround time for in-network providers is three days from receipt of the request for a determination. Cigna-HealthSpring reviews requests made after hours, weekends and holidays on the following business day.

The provider faxes the completed form to Cigna-HealthSpring at one of the following numbers which are confidential fax lines and are available twenty-four (24) hours per day, seven (7) days per week:

- > Inpatient Authorization Requests: **1-877-809-0786**
- > Outpatient Authorization Requests: **1-877-809-0787**
- > Alternatively, providers may initiate a prior authorization request through Cigna-HealthSpring's Provider Portal at <https://starplus.hsconnectonline.com> or by calling the Cigna-HealthSpring's Prior Authorization Department at **1-877-725-2688**. The Prior Authorization Department is available Monday to Friday from 8 a.m. to 5 p.m. Central Time. When calling for a prior authorization, providers should be prepared to provide the following information over the telephone:
 - > Member name and Medicaid identification number
 - > Location of service e.g., office, hospital or surgery center setting;
 - > PCP name/Requesting provider name
 - > Servicing/Attending physician name
 - > Date of service
 - > Diagnosis
 - > Service/Procedure/Surgery description and CPT or HCPCS code
 - > Fax clinical information supporting the need for the service to be rendered

A prior authorization request is reviewed by a nurse who completes the medical necessity screening. It may be necessary to collect additional information from the ordering provider such as or clinical information that is necessary to make the decision.

If the prior authorization request is approved, Cigna-HealthSpring will issue an authorization number that can be used when billing for the approved services. Authorization is not a guarantee of claim payment. If approved, Cigna-HealthSpring will fax the authorization letter along with the authorization number, back to the requesting provider and mail an approval letter to the member.

Authorization determinations are made according to the following timeframes:

- Standard Request: Cigna-HealthSpring will respond with a determination within three (3) business days of receipt of the request.
- Urgent Request: An urgent request can be requested if/when the provider believes that waiting for a decision under the standard request timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. For these cases, providers may make an urgent request. If Cigna-HealthSpring confirms the situation is truly urgent, Cigna-HealthSpring will respond within one (1) business day.
- Emergency Room Admissions: Prior authorization is not required for Emergency Room Services. However, providers must notify Cigna-HealthSpring if the member is admitted inpatient after receiving Emergency Room Services by the next business day.
- Post-Stabilization Request: Post-stabilization requests can be made for covered services related to an Emergency Medical Condition provided after a member has been stabilized. These are services to maintain the stabilized condition or, under certain circumstances, are not pre-approved but are administered to maintain, improve, or resolve the member's stabilized condition. Cigna-HealthSpring will respond to post-stabilization requests within one (1) hour.

Inpatient Authorization (Initial and Concurrent)

Initial Review: All inpatient admissions require authorization; scheduled and unscheduled. Many members are admitted through the emergency room. If the member is admitted into observation status at an in-network hospital, an authorization is not required. However; should the member be admitted inpatient, then an authorization is required. Providers are required to provide Cigna-HealthSpring with notification of the following types of admissions:

- Elective Admissions
- Emergency and Urgent Inpatient Admissions
- Admissions following outpatient procedures
- Admissions following Observation Status
- All inpatient physical and behavioral health admissions

- Skilled Nursing Facility
- Inpatient Rehabilitation
- Long Term Acute Care

Notifications must be made by the next business day. If the admission occurs during a holiday or weekend, then notification must be made by close of the next business day. Admission notification may be made by calling Cigna-HealthSpring's Health Services Department at **1-877-725-2688** and follow the prompts for prior authorization, or by faxing a Prior Authorization Form to **1-877-809-0786**. The "Prior Authorization Request Form" can be found in the Appendices of this provider manual or on the Cigna-HealthSpring website at <http://www.cigna.com/medicare/healthcare-professionals/tx-mmp>.

DRG vs Per Diem-Concurrent Review: Cigna-HealthSpring will establish medical necessity for the admission for either type admission. The difference is the UM team will continue to follow the DRG admission for discharge needs only whereas for per diem admissions, each day stands alone for medical necessity review. The UM team will authorize a few days at a time getting a clinical update periodically as well follow for discharge needs.

Span of Coverage (Hospital) - Responsibility during a Continuous Inpatient Stay ¹

| | Scenario | Hospital Facility Charge |
|---|--|--|
| 1 | Client moves from FFS to STAR+PLUS Plan | FFS |
| 2 | Client moves from FFS to STAR+PLUS Plan but is transferred with no other break in service | FFS (original coverage at initial admit prior to transfer) |
| 3 | Client moves from STAR+PLUS Plan to FFS | STAR+PLUS |
| 4 | Client moves from STAR+PLUS Plan to FFS but is transferred with no other break in service | STAR+PLUS Plan (original coverage at initial admit prior to transfer) |
| 5 | Client moves from STAR+PLUS Plan to a new STAR+PLUS Plan | Former STAR+PLUS Plan |
| 6 | Client moves from STAR+PLUS Plan to a new STAR+PLUS Plan but is transferred with no other break in service | Former STAR+PLUS Plan (original coverage at initial admit prior to transfer) |
| 7 | Client moves from STAR+PLUS to a STAR HEALTH Plan | STAR+PLUS Plan |
| 8 | Client moves from STAR+PLUS to a STAR HEALTH Plan but is transferred with no other | STAR+PLUS Plan (original coverage at initial admit prior to transfer) |

| | Scenario | Hospital Facility Charge |
|----|---|--|
| | break in service | |
| 9 | Client moves from STAR HEALTH to a STAR+PLUS Plan | STAR HEALTH |
| 10 | Client moves from STAR HEALTH to a STAR+PLUS Plan but is transferred with no other break in service | STAR HEALTH (original coverage at initial admit prior to transfer) |
| 11 | Client moves from FFS to STAR HEALTH | FFS |
| 12 | Client moves from FFS to STAR HEALTH but is transferred with no other break in service | FFS (original coverage at initial admit prior to transfer) |
| 13 | Client moves from STAR HEALTH to FFS | STAR HEALTH |
| 14 | Client moves from STAR HEALTH to FFS but is transferred with no other break in service | STAR HEALTH (original coverage at initial admit prior to transfer) |
| 15 | Client is retroactively enrolled in STAR or STAR+PLUS | New MCO |

Discharge Planning

Discharge Planning is a critical component of the utilization management process that begins upon admission with an assessment of the member's potential discharge care needs. It includes preparation of the member and his/her family for continuing care needs, medications and initiation of services needed after acute care discharge. It is the responsibility of the hospital to ensure a safe discharge for our members. Any services the member will need upon discharge should be discussed with the Cigna-HealthSpring Utilization Management nurse to ensure all authorizations are completed prior to the member being discharged. It is imperative that all services are arranged and authorized as needed. The Utilization Management team can assist with providing names and phone numbers of in-network providers.

Examples of medical care and services that can be arranged in the discharge planning phase include:

- > Home health care
- > Physical therapy
- > Speech therapy
- > Occupational therapy
- > DME
- > Home infusion therapy
- > Wound care

The member's assigned Service Coordinator participates in the discharge planning process as well to ensure seamless transition back to the community home and immediate resumption of services that were in place prior to the admission.

For behavioral health-related discharges, an outpatient appointment with a behavioral health practitioner, medication management, crisis and recovery planning, partial hospitalization, residential care, day care, and psychosocial rehabilitation will be arranged to meet the individual's needs in partnership with the member's assigned Service Coordinator and Behavioral Health Case Manager.

Discharge instructions should be faxed to the Utilization Management Intake fax **1-877-809-0786** at the time of discharge.

Failure to Obtain an Authorization

Failure to obtain prior authorization for services that require authorization may result in non-payment of services. It is important to note that authorization does not guarantee payment. An authorization addresses the medical necessity of a service, procedure, admission, etc. Eligibility at the time service is rendered and benefit coverage are separate and distinct issues.

Direct Access Services

Cigna-HealthSpring Medicare-Medicaid Plan members may access any specialist without a referral from their PCP as long as they are in-network with Cigna-HealthSpring CarePlan. Please note that some specialists require a referral from a PCP before they will consider seeing a member. Some specialists want to review clinical information on the member prior to accepting them for care.

Out of Network Authorizations

All non-emergent, out of network services require prior authorization. Prior to referring out-of-network or out of the service area, the PCP should document the justification for out-of-network services and obtain prior authorization from Cigna-HealthSpring. Once an out of network request is received, Cigna-HealthSpring must investigate to see if there is an

in-network provider that can provide the services being requested. For outpatient services Cigna-HealthSpring's goal is to transition and/or direct the member to an in-network provider. If an in-network provider is available, then the out of network provider may choose to rescind the request or may request a formal denial.

Continuity of Care

Cigna-HealthSpring ensures that new CarePlan members receiving acute care services through a prior authorization as of the Cigna-HealthSpring operational start date receive continued authorization of those services for the shorter of:

- > 90 calendar days after operational start date
- > Until the expiration date of the prior authorization
- > Ability to transition to an in-network provider in less than 90 days

Cigna-HealthSpring ensures that CarePlan members receiving Long Term Services and Support as of the operational start date may receive continued authorization of those services for up to six (6) months after the operational start date, unless a new assessment has been completed and new authorizations issued.

Pregnant Members with sixteen weeks or fewer remaining before the expected delivery date must be allowed to remain under the care of their current OB/GYN through the Member's post-partum checkup if the OB/GYN provider is, or becomes out-of-network. The Member also may select an OB/GYN within the network, if she chooses to do so and if the new OB/GYN provider agrees to accept her.

Member Moves Out of Service Area

Members who move out of the Service Area are responsible for obtaining a copy of their medical records from their current provider on behalf of their new PCP. Participating Cigna-HealthSpring providers are required to furnish members with copies of their medical records.

Pre-existing Conditions

Cigna-HealthSpring does not have a pre-existing condition limitation. Cigna-HealthSpring provides all covered services to new members beginning on the member's date of enrollment into Cigna-HealthSpring, regardless of any pre-existing conditions, prior diagnoses and/or receipt of prior health care services.

Cigna-HealthSpring makes special provisions for new members who are considered in an "Active Course of Treatment" such as intensive cancer treatment. An Active Course of Treatment is a planned program of services rendered by a provider that starts on the date a provider first renders services to correct or treat the diagnosed condition. An Active Course of Treatment covers a defined number of services or a period of treatment and one that would be difficult to transition to another provider in the midst of treatment. For members in an Active Course of Treatment with an out-of-network provider at the time of enrollment, Cigna-HealthSpring will authorize out-of-network services until the member's records, clinical information and care can be transferred to an in-network provider or until ninety (90) days from enrollment in Cigna-HealthSpring, the active course of treatment is completed, or the member is no longer enrolled in Cigna-HealthSpring, whichever of the three is shortest.

Cigna-HealthSpring Medical Management will coordinate all necessary referrals and authorizations to ensure care is not interrupted during a new member's transition. Out-of-network

providers who continue treating Cigna-HealthSpring members during a transition period must:

- > Continue to provide the members' treatment and follow-up
- > Accept Cigna-HealthSpring reimbursement rates
- > Share information regarding the treatment plan with Cigna-HealthSpring
- > Refer in-network for laboratory, radiology services, or hospital services

All requests for out-of-network, continuity of care are reviewed on a case-by-case basis by Cigna-HealthSpring. All requests not meeting the conditions for continuity of care will be forwarded to the Medical Director who will review the request.

If notification is not provided according to the guidelines above, authorization will not be granted and claims for services will be denied. Claim denials for no authorization may be appealed and will be subject to review. Cigna-HealthSpring may ask for the reason why the Provider did not request a timely notification as well as clinical documentation.

BILLING AND CLAIMS ADMINISTRATION

Claims Submission

There are three ways to file a claim:

- > Electronically (Payer ID #52192) – via 1 of the following 3 Cigna-HealthSpring claims clearing houses: (1) Change Healthcare (formerly Emdeon), (2) PayerPath, or (3) Availity
- > Via secure Provider Portal – for individual and batch claims Via Mail – Send paper claims to (see claims addresses list below)
- > Via TMHP State's website – Acute Care can visit the website <http://www.tmhp.com/> and click on 'Providers' in the top header. Then Click 'Go to TexMedConnect' in the upper right corner

Claim Submission Requirements

This section contains claim filing reminders and instructions for the completion of a CMS-1500 and UB-04 claim form. Although this section references how to file a paper claim, many of the same requirements apply to claims submitted electronically. For questions call the Cigna-HealthSpring Provider Services Department at **1-877-653-0331**.

Important note: Although Cigna-HealthSpring follows many of the same claim filing requirements as Texas Medicaid & Healthcare Partnership (TMHP) for FFS Medicaid claim filing; Cigna-HealthSpring is also required to follow additional

Federal requirements. These additional Federal requirements may cause differences in claim filing requirements for Cigna-HealthSpring members.

Claims Addresses

As indicated in the table below, providers should submit claims based on the type of services provided.

| Type of Service | Claims Address |
|--|---|
| Acute physician care, hospital services, emergency services and Long-Term Services and Supports (LTSS) | <p>Paper Claims: Cigna-HealthSpring -Medicare-Medicaid Plan P.O. Box 981709 El Paso, TX 79998-1709</p> <p>Electronic Claims: Payer ID is 52192</p> |
| Behavioral Health services (including inpatient behavioral health claims) | <p>Paper Claims: Cigna-HealthSpring -Medicare-Medicaid Plan P.O. Box 981709 El Paso, TX 79998-1709</p> <p>Electronic Claims: Payer ID is 52192</p> |
| Dental services | <p>Paper Claims: DentaQuest-Claims 12121 North Corporate Parkway Mequon, WI 53092</p> <p>Electronic Claims: Change Healthcare (formerly Emdeon)/Availity Payer ID: CX014</p> |
| Vision services | <p>Paper Claims: Superior Vision Attn: Claims 939 Elkridge Landing Road, Ste 200 Linthicum, MD 21090</p> <p>Electronic Claims: Online via https://www.blockvisiononline.com/login</p> |

Submitted MCO and Dental Plan Claims to TMHP for Proper Routing:

- Using TexMedConnect: Log in to the TMHP secure website and submit the claims to TMHP
- Through EDI: Log in to the claims billing software and submit the claims through EDI to TMHP

Note: Each claim must contain services administered by a single entity, either all fee-for-services (including services for fee-for-service clients and carve-out services), all MCO services, or all dental plan services. Fee-for-service procedures and MCO procedures for the same client cannot be billed on the same claim. Each claim may be submitted individually or in a batch.

Each batch may contain claims destined for a variety of plans including fee-for-service and managed care. Providers receive a message that indicates whether the claim was transmitted successfully or unsuccessfully

Claims Filing Deadline

Providers must submit claims to Cigna-HealthSpring within ninety-five (95) days from the date the covered service was rendered. If the claim is not filed with Cigna-HealthSpring within ninety-five (95) days from the date of service, the claim will be denied.

| Submission | Filing deadline |
|---|---|
| Initial submission submitted to the correct plan | 95 days from the DOS |
| Initial submission submitted to the wrong plan | 95 days from the date on the Remittance and Status (R&S) report from the other (wrong) carrier (documentation of timely filing is required) |
| Initial submission to TPR (not the Medicaid MCO or dental plan) | 95 days from the date of disposition by the other insurance resource |
| Initial submission for newborns | Submit the client's or mother's MCO within 95 days of the DOS |

Clean Claim

A clean claim is a complete and accurate claim form that is submitted for a medical or health care service that includes all provider and member information. A provider submits a clean claim by providing the required data elements on the standard claim form, whether it is a UB-04 or CMS-1500. Clean claims are received within 95 (ninety-five) days of the date of service.

A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837-(claim type) encounter guides as follows: (a) 837 Professional Combined Implementation Guide; (b) 837 Institutional Combined Implementation Guide; (c) 837 Professional Companion Guide; and (d) 837 Institutional Companion Guide.

Additional information on clean claim definitions and data elements are provided at Tex. Ins. Code §843, Subchapter J;

28 Tex. Admin. Code §11.901(a)(8); 28 Tex. Admin. Code Chapter 21, Subchapter Corrected Claim.

A corrected claim is a claim that has already been adjudicated, whether paid or denied. A provider would submit a corrected claim if the original claim adjudicated needs to be changed. A corrected claim could be a result of:

- Errors were found involving diagnosis, procedure, date or modifier
- Claims contained missing, incorrect, or incomplete data according to our claims submission requirements
- Services were missed in an original claim
- Original claim billed with incorrect number of units or billed amount

Corrected claims must be sent within 60 days of initial claim disposition. Failure to mark the claim as Corrected could result in a duplicate claim and be denied for exceeding the 95 days timely-filing deadline.

Claim Filing Formats

Cigna-HealthSpring accepts claims in both electronic and paper formats. Electronic claims are the preferred method of submission. Electronic claims can be submitted to Cigna-HealthSpring through Change Healthcare (formerly Emdeon), or TMHP (TexMedConnect/ the TMHP EDI Gateway) or Availity (formerly T.H.I.N.), or PayerPath, or through HS Connect, which is Cigna-HealthSpring's Provider Portal.

Electronic claims must be submitted using the HIPAA-complaint American National Standards Institute (ANSI) ASC X12 5010 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. For additional information refer to Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information).

The Cigna-HealthSpring Payer ID is 52192. Questions regarding Change Healthcare (formerly Emdeon) electronic claims submission can be directed to Change Healthcare (formerly Emdeon) at **1-800-845-6592** or providers may refer the Change Healthcare (formerly Emdeon) website at <http://changehealthcare.com/>.

Paper claims must be submitted on a CMS 1500 or UB 04 form. The type of form used is based on the provider type, and service provided; see Claim Submission Requirements for more information on type of form to use for claim filing.

Acute care providers may also submit claims through an HHSC-designated portal.

National Provider Identification (NPI) Numbers

A NPI number is a standard, nationally-assigned, "non-intelligent" provider identifier that is required to be used in all electronic health care transactions effective May 27, 2008. Providers who do not have a NPI number can obtain one by calling **1-800-465-3203** (TTY **1-800-692-2326**) or by emailing memberservice@npienumerator.com. Providers also may obtain a NPI by writing to **NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059**.

After receiving a NPI number, Texas Medicaid providers must "attest" their NPIs and related data to TMHP. Related data includes a taxonomy code and a physical address with a ZIP+4 Codes. During attestation some providers may also be assigned a benefit code to identify specific state programs as part of their NPI-related data. NPIs can be attested on the TMHP website at <http://www.tmhp.com>. The information required for attestation includes the provider's:

- TPI
- NPI or API
- Taxonomy
- Physical Address
- National Plan and provider Enumeration System Data
- NPI - Group Providers
- Providers billing as a group must give the performing provider NPI on their claims as well as the group NPI.
- NPI – Supervising Physician Providers

The supervising provider number is required on claims for services that are ordered or referred by one provider at the direction of or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the member.

If a referral or order for services to a Texas member is based on a member evaluation that was performed by the supervised provider, the billing provider's claim must include the names and NPIs of both the ordering provider and the supervising provider. The billing provider must obtain all of the required information from the ordering or referring provider before submitting the claim to Cigna-HealthSpring.

All paper claims must be submitted with a Texas Provider Identifier (TPI) and an attested National Provider Identifier (NPI) for the billing and performing providers. All other provider fields on the claim forms require an NPI only. If a NPI and TPI are not included in the billing and performing provider fields, or if a NPI is not included on all other provider identifier fields, the claim will be denied.

Providers billing for LTSS services should refer to the LTSS billing guide for additional information on paper claim submission.

When filing electronic claims, providers must submit their NPI or API number, whichever is applicable, and their taxonomy code. Some LTSS providers are not eligible for a NPI. These providers must request an API number from Cigna-HealthSpring.

Diagnosis Coding

Cigna-HealthSpring requires providers to provide International Classification of Disease, Ninth Revision, Clinical Modification (ICD-10-CM) diagnosis codes on their claims. Diagnosis codes must be to the highest level of specificity available. All diagnosis codes must be appropriate for the age of the member as identified in the ICD-10-CM description of the diagnosis code. Claims that are submitted without a valid ICD-10 code will be denied. (Block # 67, 67A-67Q, 69, 70A-70C, and 72A-72C - UB-04; Block 21 for CMS-1500)

Present on Admission (POA)

Present on Admission (POA) is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, and outpatient surgery, are considered POA.

Hospital providers that are reimbursed under prospective payment basis methodology (diagnosis related grouping (DRG) will be required to submit a “present on admission” (POA) value for **all** diagnoses on inpatient hospital claims. Claims that are submitted without the required POA indicator will be denied. (Block # 67, 67A-67Q – UB-04)

Place of Service (POS) Coding

| POA Value | Description | Payment |
|-----------|--|--|
| Y | Diagnosis was present at the time of admission | Payment will be made by Medicaid when a Hospital Acquired Condition (HAC) is present |
| N | Diagnosis was not present at the time of admission | No payment will be made by Medicaid when an HAC is present. |
| U | Documentation was insufficient | No payment will be made by Medicaid when an HAC is present |
| W | Clinically undetermined | Payment will be made by Medicaid when an HAC is present |

The POS identifies where services are performed. POS is required only on a CMS-1500 form.

(Block # 24b - CMS-1500)

The table below shows valid POS codes:

| Place of Service POS | 2-Digit Numeric Codes |
|--|---|
| Office | 11,15,20,49,50, 60, 65, 71,72 |
| Home | 12 |
| Inpatient Hospital | 21,51,52,55,56,61 |
| Outpatient Hospital | 22,23,24,62 |
| Birthing Center | 25 |
| Other Location | 01,03,04,05,06,07,08,16, 26,34,53,57,99 |
| Skilled nursing facility, intermediate care facility, intermediate care facility for mentally challenged | 13,31,32,54 |
| Extended care facility (rest home, domiciliary or custodial care, nursing facility boarding home) | 14,33 |
| Independent Lab | 81 |
| Ambulance | 41,42 |

Note: Family planning and THSteps medical services performed in a rural health clinic (RHC) are billed using POS 72

Procedure Coding

Cigna-HealthSpring uses a coding system called Healthcare Common Procedure Coding System (HCPCS) code set. HCPCS provides health-care providers and payers a common coding structure that is designed around a five-character numeric or alphanumeric base for all codes. Claims submitted without a valid HCPCS codes will be denied. (Block # 44 – UB-04; 24d – CMS-1500)

HCPCS consists of two levels of codes including the Current Procedural Terminology (CPT®) Professional Edition (Level I) and the HCPCS codes approved and released by CMS (Level II)

Level I

CPT® Professional Edition:

- All numeric
- Consist of five digits
- Represent 80 percent of HCPCS

- > Maintenance
- Responsibility of the AMA, which updates annually
- Updates by the AMA are coordinated with CMS before distribution of modification to third party payers
 - > Anesthesia codes from CPT

Level II

HCPCS codes:

- > Approved and released by CMS
- > Codes for both physician and non-physician services not contained in CPT (for example, ambulance, DME, prosthetics, and some medical codes)
- > Updating: Responsibility of the CMS Maintenance Task Force
- > All alphanumeric consisting of a single alpha character (A through V) followed by four numeric digits

The single alpha character represents the following:

| Alpha | Description |
|-------|--|
| A | Supplies, ambulance, administrative, miscellaneous |
| B | Enteral and parenteral therapy |
| E | DME and oxygen |
| G | Procedures/professional (temporary) |
| H | Rehab and behavioral health services |
| J | Drugs (administered other than orally) See NDC requirements |
| K | Durable Medical Equipment Regional Carriers (DMERC) |
| L | Orthotic and prosthetic procedures |
| M | Medical |
| P | Laboratory |
| Q | Temporary procedures |
| R | Radiology |
| S | Private payer |
| T | State Medicaid agency |
| V | Vision and hearing services |

National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered. If the NDC is indicated on the box, and vial of a medication, enter the NDC from the vial. Providers must submit a NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure.

- > Codes in the A code series do not require a NDC.
- > N4 must be entered before the NDC on claims.

The units of measurement codes can also be submitted, however, are not required. The codes to be used for all claim forms are:

- > F2 – International unit
- > GR – Gram
- > ML – Milliliter
- > UN – Unit

Unit quantities can also be submitted, however, are not required.

Depending on the claim type, the NDC information must be submitted as indicated below for paper claims, or the equivalent electronic field. Claims requiring the NDC but submitted with an invalid HCPCS-NDC combination, or without the required NDC will be denied.

UB-04

| Block # | Description | Guidelines |
|---------|-------------------------------|--|
| 43 | Revenue codes and description | <ul style="list-style-type: none"> > Enter N4 and the 11 digit NDC number (number on the package or container from which the medication was administered). > Optional: The unit of measurement code and the unit quality with a floating decimal for fractional units (limited to 3 digits) can also be submitted, however, are not required. > Do not enter hyphens within this number > Example: N400409231231GR0.025 |

CMS-1500

| Block # | Description | Guidelines |
|---------|------------------|---|
| 24 A | Dates of service | In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number |

| Block # | Description | Guidelines |
|---------|----------------------------------|--|
| | | on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231 |
| 24 D | Procedures, services or supplies | Optional: In the shaded area, enter a 1-through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. |
| 24 G | Days or units | Optional: In the shaded area, enter the NDC unit of measurement code. |

FQHC Claim Filing Instructions

Billable Services

The services listed in the tables below may be reimbursed to FQHCs using the FQHCs attested National Provider Identifier (NPI).

| Service | Code(s) | Description |
|--------------------------|--|--|
| General Medical Services | T1015 | General Medical services must be submitted using one of the appropriate modifiers AH, AJ, AM, SA, TD, TE, TH, or U7. |
| Adult Preventative Care | 99385 99386 99387 99395 99396 99397 | Adult preventative care must be submitted with diagnosis code V700. |
| Family Planning Services | 99201 99202 99203 99204 99205 99211 99212 99213, 99214 99215 J7300 J302 J307 | Annual family planning examination must be submitted with modifier FP. |

| | | |
|------------------------|--|--|
| Mental Health Services | 90791 90792 90832 90833* 90834 90836* 90837 90838* 90847 90853 90865 96101 96118 | *Procedures cannot be performed by Psychologist. Mental health services must be submitted using one of the appropriate modifiers AH, AJ, AM, U1, or U2. |
|------------------------|--|--|

Services not listed above must be billed using the rendering provider billing information.

RHC Claim Filing Instructions

Billable Services

The services listed in the tables below may be reimbursed to RHCs using the RHCs attested National Provider Identifier (NPI).

| Service | Code(s) | Description |
|--|---------|--|
| General Medical Services (encounter may be reimbursed to the RHC facility only) | T1015 | General Medical services must be submitted using one of the appropriate modifiers AJ, AM, SA, TD, TE, TH, or U7. Adult preventative care must be submitted with diagnosis code V700. |

Note: If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to clarify the service that was performed.

Services not listed above must be billed using the rendering provider billing information.

Claim Filing Instructions – CMS-1500

Below is the minimum data required to process a claim on a CMS 1500 form. Any missing or invalid data will result in a claim denial. Claim information must match the referral/authorization information.

The CMS-1500 form is used by the following providers:

- > Ambulance
- > ASC (freestanding)
- > Certified Nurse-Midwife (CNM)
- > Certified Registered Nurse Anesthetist (CRNA)
- > Chemical dependency treatment facilities
- > Chiropractor
- > Clinical Nurse Specialist (CNS)

- > Dentist (doctor of dentistry practicing as a limited physician)
- > DME or durable medical equipment-home health services (DMEH) supplier (CCP and home health services)
- > Family planning agency that does not also receive funds from the DSHS Family Planning Program
- > FQHC
- > Genetic service agency
- > Hearing aid
- > In-home Total Parental Nutrition (TPN) supplier
- > Laboratory
- > Licensed dietitian (CCP only)
- > Licensed Clinical Social Worker (LCSW)
- > Licensed Professional Counselor (LPC)
- > Maternity Service Clinic (MSC)
- > Mental Health (MH) rehabilitative services
- > Nurse Practitioner (NP)
- > Occupational therapist (CCP only)
- > Pharmacy
- > Physician (group and individual)
- > Physician Assistant (PA)
- > Podiatrist
- > Private Duty Nurse (PDN) (CCP only)
- > Psychologist
- > Radiology
- > Rural health clinics rendering services to THSteps clients
- > School Health and Related Services (SHARS)
- > Speech Language Pathologist (CCP only)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|--------|---|--|--|--|--|--|--|---------------|--|------------------|--|-------------------------|--|--------------|--|-----------------------------|--|
| PICA <input type="checkbox"/> | | | | | | | | | | PICA <input type="checkbox"/> | | | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BENEFIT <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#) | | | | | | | | | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | | | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | | | | | | | | | |
| CITY | | | | | STATE | | | | | 7. INSURED'S ADDRESS (No., Street) | | | | | 8. RESERVED FOR NUCC USE | | | | | | |
| ZIP CODE | | | | | TELEPHONE (Include Area Code) () | | | | | CITY | | | | | STATE | | | | | | |
| ZIP CODE | | | | | TELEPHONE (Include Area Code) () | | | | | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | b. RESERVED FOR NUCC USE | | | | | c. RESERVED FOR NUCC USE | | | | | d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | |
| a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ | | | | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | 10d. CLAIM CODES (Designated by NUCC) | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____ | | | | | | | | | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____ | | | | | | | | | | 15. OTHER DATE MM DD YY QUAL _____ | | | | | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | | | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | | | | | | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____ | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ | | | | | | | | | | 22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ | | | | | | | | | | | |
| A. _____ B. _____ C. _____ D. _____ | | | | | | | | | | E. _____ F. _____ G. _____ H. _____ | | | | | | | | | | | |
| I. _____ J. _____ K. _____ L. _____ | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER _____ | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | B. PLACE OF SERVICE | | C. EMG | | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | | | E. DIAGNOSIS POINTER | | F. \$ CHARGES | | G. DAYS OR UNITS | | H. EPF/OT (Family Plan) | | I. ID. QUAL. | | J. RENDERING PROVIDER ID. # | |
| 1 | | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> | | | | | | | | | | 26. PATIENT'S ACCOUNT NO. | | | | | | | | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____ | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | |
| a. NPI | | | | | | | | | | b. NPI | | | | | | | | | | | |
| 27. ACCEPT ASSIGNMENT? (If Govt. agency, see book) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | 28. TOTAL CHARGE \$ _____ | | | | | | | | | | | |
| 29. AMOUNT PAID \$ _____ | | | | | | | | | | 30. Rcvd for NUCC Use | | | | | | | | | | | |
| 33. BILLING PROVIDER INFO & PH # () | | | | | | | | | | | | | | | | | | | | | |

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Requirements for CMS 1500

| Block # | Description | Guidelines |
|-------------------|--|---|
| 1a | Insured's ID No. (for program checked above, include all letters) | Enter the client's nine-digit patient number from the Medicaid identification form. <ul style="list-style-type: none"> > For other property and casualty claims: Enter the Federal Tax ID or SNN of the insured person or entity. |
| 2 | Patient's name | Enter the client's last name, first name, and middle initial as printed on the Medicaid identification form. <ul style="list-style-type: none"> > If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name. |
| 3 | Patient's date of birth Patient's sex | Enter numerically the month, day and year (MM/DD/YYYY) the client was born. Indicate the client's gender by checking the appropriate box. <ul style="list-style-type: none"> > Only one box can be marked. |
| 5 | Patient's address | Enter the client's complete address as described (street, city, state, and SIP code). |
| 9 | Other insured's name | For special situations, use this space to provide additional information such as: <ul style="list-style-type: none"> > If the client is deceased enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b. |
| 10a 10b 10c | Is patient's condition related to: <ul style="list-style-type: none"> > Employment (current or previous)? > Auto accident? > Other accident? | Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b. |
| 11 11a 11b | Other health insurance coverage | <ul style="list-style-type: none"> > If another insurance resource has made payment of denied a claim, enter the name of the insurance company. The other insurance EOP or denial letter must be attached to the claim form. > If the client is enrolled in Medicare attach a copy of the MRAN to the claim from. > For Workers Compensation and other property and casualty claims: (Required if known) Enter Worker's Compensation or property and casualty claim number assigned by the payer. |
| 11c | Insurance plan or program name | Enter the benefit code, if applicable, for the billing or performing provider. |
| 12 | Patient's or authorized person's signature | Enter "Signature on File," "SOF," or legal signature. When legal signature is entered, enter the date signed in eight digit formation (MMDDYYYY). <ul style="list-style-type: none"> > TMHP will process the claim without the signature of the patient. |
| 14 | Date of current | Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. <ul style="list-style-type: none"> > If the client has chronic renal disease, enter the date of the onset of dialysis treatments. > Indicate the date of treatments for PT and OT. |

| Block # | Description | Guidelines |
|---------|---|--|
| 17 | Name of referring physician or other source | <p>Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supplies on the claim. If multiple providers are involved, enter one provider using the following priority order:</p> <ul style="list-style-type: none"> > Referring Provider > Ordering Provider > Supervising Provider <p>Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported.</p> <ul style="list-style-type: none"> > DN = Referring Provider > DK = Ordering Provider > DQ= Supervising Provider <p>Supervising Physician for Referring Physicians: If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and the NPI of the supervising provider must go in Block 19.</p> |
| 17b | NPI | Enter the NPI number of the referring, ordering, or supervising provider |
| 19 | Additional claim information | <ul style="list-style-type: none"> > Ambulance transfers of multiple clients > If the claim is part of a multiple transfer, indicate the other client's complete name and Medicaid number. <p>Ambulance Hospital-to-Hospital Transfers</p> <ul style="list-style-type: none"> > Indicate the services required from the second facility and unavailable at the first facility > Supervising Physician for Referring Physicians: If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19. |
| 20 | Outside lab | <p>Check the appropriate box. The information may be requested for retrospective review.</p> <ul style="list-style-type: none"> > If "yes," enter the provider identifier of the facility that performed the service in block 32. |
| 21 | Diagnosis or nature of illness or injury | <p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported</p> <ul style="list-style-type: none"> > 9=ICD-9-CM > 0=ICD-10-COM <p>Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes.</p> <ul style="list-style-type: none"> > Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. > Do not provide narrative description in this field. |
| 23 | Prior authorization number | <p>Enter the PAN issued by TMHP.</p> <ul style="list-style-type: none"> > For Workers Compensation and other property and casualty claims, this is required when prior authorization referral, concurrent review, or voluntary |

| Block # | Description | Guidelines |
|---------|--|---|
| | | certification was received. |
| 24 | (Various) | <p>General notes for blocks 24a through 24j:</p> <ul style="list-style-type: none"> > Unless otherwise specified, all required information should be entered in the unshaded portion. > If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim. > For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form. |
| 24a | Date(s) of service | <p>Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line.</p> <p>NDC</p> <ul style="list-style-type: none"> > In the shaded area, enter the NDC qualifier of the N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). – Do not enter hyphens or spaces within this number. – Example: N400409231231 > Refer to: Subsection 6.3.4, “National Drug Code (NDC)” in this section. |
| 24b | Place of service | <p>Select the appropriate POS code for the service from the table under the subsection 6.3.1.1, “Place of Service (POS) Coding” in this section.</p> |
| 24c | EMG (THSteps medical checkup condition indicator) | <p>Enter the appropriate condition indicator for the THSteps medical Checkups.</p> <ul style="list-style-type: none"> > Refer to: Subsection 5.3.6, “THSteps Medical Checkups” in Children’s Services Handbook (Vol. 2 Provider Handbooks). |
| 24d | Fully describe procedures, medical services, or supplies furnished for each date given | <p>Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description.</p> <p>NDC</p> <ul style="list-style-type: none"> > Optional: In the shaded area, enter a 1-through 12-digit NDC quantity of unit. > A decimal point must be used for fractions of a unit. > Refer to: Subsection 6.3.4, “National Drug Code (NDC)” in this section. |
| 24e | Diagnosis pointer | <ul style="list-style-type: none"> > In 24 E, enter the diagnosis code reference letter (pointer) as shown in Form Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. > The reference letter(s) should be A-L or multiple letters as applicable. > Diagnosis codes must be entered in Form Field 21 only. > Do not enter diagnosis codes in Form Field 24E. |
| 24f | Charges | <ul style="list-style-type: none"> > Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients. |
| 24g | Days or units | <ul style="list-style-type: none"> > If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). |

| Block # | Description | Guidelines |
|---------|---------------------------------------|--|
| | | <ul style="list-style-type: none"> > Note: The maximum number of units per detail is 9,999. |
| | | <p>NDC</p> <ul style="list-style-type: none"> > Optional: In the shaded area, enter the NDC unit of measurement code. > Refer to: Subsection 6.3.4, “National Drug Code (NDC)” in this section. |
| 24j | Rendering provider ID # (performing) | <p>Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual.</p> <ul style="list-style-type: none"> > Enter the TPI in the shaded area of the field. > Enter the NPI in the unshaded area of the field. |
| 26 | Patient’s account number | <ul style="list-style-type: none"> > Optional: Enter the client identification number if it is different than the subscriber/insured’s identification number. > Used by the provider’s office to identify internal client account number. |
| 27 | Accept Assignment | <ul style="list-style-type: none"> > Required > All providers of Texas Medicaid must accept assignment to receive payment by checking Yes. |
| 28 | Total charge | <p>Enter the total charges.</p> <ul style="list-style-type: none"> > For multi-page claims enter “continue” on the initial and subsequent claim forms. Indicate the total of all charges on the last claim. > Note: Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form. |
| 29 | Amount paid | <p>Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.</p> |
| 30 | Balance due | <p>If appropriate, subtract block 29 from block 28 and enter the balance.</p> |
| 31 | Signature of physician or supplier | <ul style="list-style-type: none"> > The physician, supplier, or authorized representative must sign and date the claim. > Billing services may print “Signature on File” in place of the provider’s signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. > Refer to: Subsection 6.3.2.1, “Provider Signature on Claims” in this section. |
| 32 | Service facility location information | <p>If services were provided in a place other than the client’s home or the provider’s facility, enter name, address, and XIP code of the facility where the service was provided.</p> |
| 32A | NPI | <p>Enter the NPI of the service facility location.</p> |
| 33 | Billing provider info and PH # | <p>Enter the billing provider’s name, street, city, state, ZIP+4 code, and telephone number.</p> |
| 33A | NPI | <p>Enter the NPI of the billing provider.</p> |
| 33B | Other ID # | <p>Enter the TPI number of the billing provider.</p> |

UB-04 Claim Filing Detail

Below is the minimum data required to process a claim on a UB-04 form. Any missing or invalid data will result in a claim denial. Claim information must match the referral/authorization information.

The UB-04 form is used by the following providers

- > ASCs (hospital-based)
- > Comprehensive outpatient rehabilitation facilities (CORFs (CCP only)

- > FQHCs
- > Hospitals
- Inpatient (acute care, rehabilitation military, and psychiatric hospitals
- Outpatient
 - > Renal dialysis center
 - > RHCs (freestanding and hospital-based)

UB-04 Example

| | | | | | | | |
|-----------------------------|--|----------------------------------|--|------------------------------|--|--|--|
| 1 | | 2 | | 3a PAT. CNTL. # | | 4 TYPE OF BILL | |
| | | | | 3b MED. REC. # | | | |
| | | | | 5 FED. TAX NO. | | 6 STATEMENT COVERS PERIOD FROM THROUGH | |
| 8 PATIENT NAME | | 9 PATIENT ADDRESS | | | | | |
| 10 BIRTHDATE | | 11 SEX | | 12 DATE | | 13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21 | |
| 31 OCCURRENCE CODE | | 32 OCCURRENCE DATE | | 33 OCCURRENCE CODE | | 34 OCCURRENCE DATE | |
| 35 CODE | | 36 OCCURRENCE SPAN FROM THROUGH | | 37 CODE | | 38 OCCURRENCE SPAN FROM THROUGH | |
| 39 CODE | | 40 VALUE CODES AMOUNT | | 41 CODE | | 42 VALUE CODES AMOUNT | |
| 43 REV. CD. | | 43 DESCRIPTION | | 44 HCPCS / RATE / HIPPS CODE | | 45 SERN DATE | |
| 46 SERN UNITS | | 47 TOTAL CHARGES | | 48 NON-COVERED CHARGES | | 49 | |
| PAGE ____ OF ____ | | CREATION DATE | | TOTALS | | | |
| 50 PAYER NAME | | 51 HEALTH PLAN ID | | 52 REL. INFO | | 53 ARG. BEN. | |
| 54 PRIOR PAYMENTS | | 55 EST. AMOUNT DUE | | 56 NPI | | 57 OTHER PRV ID | |
| 58 INSURED'S NAME | | 59 P. REL. | | 60 INSURED'S UNIQUE ID | | 61 GROUP NAME | |
| 62 INSURANCE GROUP NO. | | 63 TREATMENT AUTHORIZATION CODES | | 64 DOCUMENT CONTROL NUMBER | | 65 EMPLOYER NAME | |
| 66 | | 67 | | 68 | | 69 | |
| 70 PATIENT REASON DX | | 71 PPS CODE | | 72 EDI | | 73 | |
| 74 PRINCIPAL PROCEDURE CODE | | 75 OTHER PROCEDURE CODE | | 76 ATTENDING NPI | | 77 QUAL | |
| 78 LAST | | 79 FIRST | | 80 LAST | | 81 FIRST | |
| 82 LAST | | 83 FIRST | | 84 LAST | | 85 FIRST | |
| 86 LAST | | 87 FIRST | | 88 LAST | | 89 FIRST | |
| 90 REMARKS | | 91 CC | | 92 LAST | | 93 FIRST | |
| | | 94 | | 95 LAST | | 96 FIRST | |
| | | 97 | | 98 LAST | | 99 FIRST | |
| | | 100 | | 101 LAST | | 102 FIRST | |

UB-04 CMS-1450

APPROVED OMB NO. 0938-0097

NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Requirements for UB-04

| Block # | Description | Guidelines |
|---------|-------------------------|--|
| 1 | Unlabeled | Enter the hospital name, street, city, state, ZIP+4 Code, and telephone number. |
| 3a | Patient control number | Optional: Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report. |
| 3b | Medical record number | Enter the patient's medical record number (limited to ten digits) assigned by the hospital. |
| 4 | Type of bill (TOB) | <p>Enter a TOB code.</p> <p>First Digit - Type of Facility:</p> <ul style="list-style-type: none"> > 1 Hospital > 2 Skilled nursing > 3 Home health agency > 7 Clinic (Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) and Renal Dialysis Center (RDCJ) > 8 Special facility <p>Second Digit – Bill Classification (except clinics and special facilities):</p> <ul style="list-style-type: none"> > 1 Inpatient (including Medicare Part A) > 2 Inpatient (Medicare Part B only) > 3 Outpatient > 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) > 7 intermediate care <p>Second Digit - Bill Classification (clinics only)</p> <ul style="list-style-type: none"> > 1 Rural health > 2 Hospital-based or independent renal dialysis center > 3 Free standing > 5 CORFs <p>Third Digit - Frequency:</p> <ul style="list-style-type: none"> > 0 Nonpayment/zero claim > 1 Admit through discharge > 2 Interim- continuing claim > 4 Interim-last claim > 5 Late charges-only claim > 6 Adjustment or prior claim > 7 Replacement of prior claim |
| 6 | Statement covers period | Enter the beginning and ending dates of service billed. |
| 8a | Patient identifier | <p>Optional: Enter the patient identification number if it is different that the subscriber/insured identification number.</p> <ul style="list-style-type: none"> > Used by providers office to identify internal patient account number |
| 8b | Patient name | Enter the patient's last name, first name, and middle initial as printed on the Medicaid Identification form. |
| 9a-9b | Patient address | Starting in 9a, enter the patient's complete address as described (street, city, state, and ZIP+4 Code)/ |

| Block # | Description | Guidelines |
|---------|---------------------|---|
| 10 | Birthdate | Enter the patient's date of birth (MM/DD/YYYY) |
| 11 | Sex | Indicate the patient's gender by enter an "M" or "F" |
| 12 | Admission date | Enter the numerical date (MM/DD/YYYY) or admission for inpatient claims; date of service (DOS) for outpatient claims or start of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility. |
| 13 | Admission hour | Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims. |
| 14 | Type of admission | Enter the appropriate type of admission code for inpatient claims <ul style="list-style-type: none"> > 1 Emergency > 2 Urgent > 3 Elective > 4 Newborn (This code requires the use of special source of admission code in Block 15.) > 5 Trauma center |
| 15 | Source of admission | Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, 3, or 5: <ul style="list-style-type: none"> > 1 Physician referral > 2 Clinic referral > 3 Health maintenance organization (HMO referral) > 4 Transfer from a hospital > 5 Transfer form skilled nursing facility (SNF) > 6 Transfer from another health-care facility > 7 Emergency room > 8 Court/law enforcement > 9 Information not available For type of admission 4 (newborn): <ul style="list-style-type: none"> > 1 Normal delivery > 2 Premature delivery > 3 Sick baby > 4 Extramural birth > 5 information not available |
| 16 | Discharge hour | For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30", leave the block blank. |
| 17 | Patient status | For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as the statement "through" date. <ul style="list-style-type: none"> > Refer to: Subsection 6.6.6, "Patient Discharge Status Codes" In this section. |
| 18-28 | Condition codes | Enter the two-digit condition code "05" to indicate the legal claim was filed for recovery of funds potentially due to a patient. |

| Block # | Description | Guidelines |
|---------|---------------------------------|--|
| 29 | ACDT state | Optional: Accident state. |
| 31-34 | Occurrence codes and dates | Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61, 62, and 80 must also be completed as required. <ul style="list-style-type: none"> > Refer to: Subsection 6.6.5 “Occurrence Codes” in this section. |
| 35-36 | Occurrence span codes and dates | For inpatient claims, enter code “71” if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay. |
| 39-41 | Value codes | <ul style="list-style-type: none"> > Accident hour – For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. > For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually this is the difference between the admission and discharge dates. In all circumstances, the number in the block is equal to the number of covered accommodation days listed in Block 46. > For the inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. > The sum of Blocks 39 - 41 must equal the total days billed as reflected in Block 6. |
| 42-43 | Revenue codes and description | <p>For inpatient services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodation in the order of occurrence.</p> <p>List ancillaries in ascending order. The space to the right of the dotted line is used for accommodation rate.</p> <p>NDC</p> <ul style="list-style-type: none"> > Enter N4 and the 11-dgit NDC number (number on packaged or container from which the medication was administered). > Optional: The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) can also be submitted by they are not required. > Do not enter hyphens or spaces within this number. > Example: N4004091231GR0.025 > Refer to: Subsection 6.3.4, “National Drug Code (NDC)” in this section. |
| 44 | HCPCS/rates | <p>Inpatient:</p> <ul style="list-style-type: none"> > Enter the accommodation rates per day. > Match the appropriate diagnoses listed in Blocks 67A through 67 Q corresponding to each procedure. If the procedure corresponds to more than on diagnosis, enter the primary diagnosis. > Each service and supply must be itemized on the claim form. <p>Home Health Services</p> <p>Outpatient claims must have the appropriate revenue code or narrative description.</p> <p>Outpatient:</p> <ul style="list-style-type: none"> > Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. > Each service, except for medical/surgical and Intravenous (IV) supplies and medication, must be itemized on the claim form |

| Block # | Description | Guidelines |
|-----------------|--|--|
| | | or an attached statement. |
| | | <ul style="list-style-type: none"> > Note: The UB 04 COMS 1450 paper claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-c. > If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of services. Multiple dates of service may not be combined on outpatient claims. |
| 45 | Service date | Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims. |
| 45 (line 23) | Creation date | Enter the date the bill was submitted. |
| 46 | Serv. Units | <ul style="list-style-type: none"> > Provide units of service, if applicable. > For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of prints of blood. > When billing for observation room services, the units indicated in this block should always represent hours spent in observation |
| 47 | Total charges | Enter the total charges for each service provided. |
| 47 (line 23) | Totals | Enter the total charges for the entire claim. Note: For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form. |
| 48 | Nocovered charges | If any of the total charges are noncovered, enter this amount. |
| 50 | Payer Name | Enter the health plan name. |
| 51 | Health Plan ID | Enter the health plan identification number. |
| 54 | Prior payments | Enter amounts paid by any TPR , and complete Blocks 32, 61, 62, and 80 as required. |
| 56 | NPI | Enter the NPI of the billing provider. |
| 57 | Other identifiable (ID) number | Enter the TPI number (non-NPI number) of the billing provider. |
| 58 | Insured's name | If other health insurance is involved, enter the insured's name. |
| 60 | Medicaid identification number | Enter the patient's nine-digit Medicaid identification number. |
| 61 | Insured group name | Enter the name and address of the other health insurance. |
| 62 | Insurance group number | Enter the policy number or group number of the other health insurance. |
| 63 | Treatment authorization code | Enter the prior authorization number if one was issued. |
| 65 | Employer name | Enter the name of the patient's employer if health care might be provided. |
| 67 | Principal diagnosis (DX) code and present on admission (POA) indicator | Enter the ICD-10-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. <ul style="list-style-type: none"> > Required: POA Indicator- Enter the applicable POA indicator in the shaded area for the inpatient claims. > Refer to: Subsection 6.4.7.3, "Inpatient Hospital Claims" in the shaded area for inpatient claims. |
| 67A-67Q | Secondary DX codes and POA indicator | Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. |

| Block # | Description | Guidelines |
|---------|---|--|
| | | <ul style="list-style-type: none"> > A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141"). > Exception: A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein. > Note: ICD-10-CM diagnosis codes enter in 67K-67Q are not required for systematic claims processing. > Required: POA indicator – Enter the applicable POA indicator in the shaded area for inpatient claims. > Refer to: Subsection 6.4.2.7.3, "Inpatient Hospital Claims" in this section for POA values. |
| 69 | Admit DX code | <p>Enter the ICD-10-CM diagnosis code indicating the cause of admission or include a narrative</p> <ul style="list-style-type: none"> > Note: The admitting diagnosis is only for inpatient claims. |
| 70a-70c | Patient's reason DX | Optional: New block indicating the patient's reason for visit on unscheduled outpatient claims. |
| 71 | Prospective Payment System (PPS) code | Optional: The PPS code is assigned to the claim to identify the DRG based on the grouper software call for under contract with the primary payer. |
| 72a-72c | External Cause of Injury (ECI) and POA indication | <p>Optional: Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each addition diagnosis.</p> <p>Required: POA indicator- Enter the applicable POA indicator in the shaded area for inpatient claims.</p> <p>Refer to: Subsection 6.4.2.7.3, "Inpatient Hospital Claims" in this section for POA values.</p> |
| 74 | Principal procedure code and date | Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed. |
| 74a-74e | Other procedure codes and dates | Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed. |
| 76 | Attending provider | <p>Enter operating provider's name and identifiers.</p> <ul style="list-style-type: none"> > NPI number of the attending provider are defined as those listed to the ICD-10 CM coding manual volume 3, which includes surgical, diagnostic, and medical procedures. |
| 77 | Operating | Enter operating provider's name (last name and first name) and NPI number of the operating provider. |
| 78-79 | Other | <ul style="list-style-type: none"> > Other provider's name (last name and first name) and NPI. > Other operating physician – An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. > Rendering provider - The health-care professional who performed, delivered, or completed a particular medical services or nonsurgical procedure. > Note: If the referring Physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident. |
| 80 | Remarks | <p>This block is used to explain special situations such as the following:</p> <ul style="list-style-type: none"> > The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. |

| Block # | Description | Guidelines |
|---------|-------------|--|
| | | <ul style="list-style-type: none"> > If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. > If milling for a private room, the medical necessity must be indicated, signed, and dated by the physician. > If services are the result of an accident, the cause and location of the accident must be entered in this block the time must be entered in Block 39. > If the laboratory work is sent out, the name, and address or the provider identifier of the facility where the work was forwarded must be entered in this block. > If the patient is deceased, enter the date of death and indicate "DOD. If services were rendered on the date of death enter the time of death. > If the services resulted from a family planning provider's referral, write "family planning referral." > If services were provided at another facility, indicate the name and address of the facility where the services were rendered. > Request for 110-day rule for a third party insurance. |

81A-81D Code code (CC) **Optional:** Are to capture additional information necessary to adjudicate the claims, required when, the judgment of the provider, the information is needed to substantiate the medical treatment and is not support elsewhere on the claim data set.

Occurrence Codes

| Code | Description | Guidelines |
|------|---|---|
| 01 | Auto accident/auto liability insurance involved | Enter the date of auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault. |
| 02 | Auto or other accident/no fault involved | Enter the date of the accident including auto or other where no fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50 and 51 to document coordination of benefits with the no-fault insurer. |
| 03 | Accident/tort liability | Enter the date of an accident (excluding automobile) resulting from a third part action. This incident may involve a civil court action in an attempt to require payment by the third part other than no-fault liability. <ul style="list-style-type: none"> > Refer to: Subsection 4.14.6, "Third Part Liability – Tort" in section 4, "Client eligibility (Vol. 1, General Information). |
| 04 | Accident employment-related | Enter the date of an accident that allegedly relates to the patient's employment and involves compensation or employer liability |
| 05 | Other accident | Enter the date of an accident not described by the above codes <ul style="list-style-type: none"> > Use this code to report no other casualty related payers have been determined. |
| 06 | Crime victim | Enter the date on which a medical condition resulted from alleged criminal action. |
| 10 | Last menstrual period | Enter the date of the last menstrual period when the service is maternity-related |
| 11 | Onset of symptoms | Indicate the date the patient first become aware of the symptoms or illness being treated. |
| 16 | Date of last therapy | Indicate the last day of therapy services for OT, PT, or speech therapy (ST). |
| 17 | Date outpatient OT plan established | Indicate the date a plan was established or last reviewed for occupation therapy. |

| | | |
|----|--|--|
| | or last reviewed | |
| 24 | Date other insurance denied | Enter the date of denial of coverage by TPR. |
| 25 | Date benefits terminated by primary payer | Enter the last date for which benefits are being claimed. |
| 27 | Date home health plan of treatment was established | Enter the date the current plan of treatment was established |
| 29 | Date outpatient PT plan established or last reviewed | Indicate the date a plan of treatment was established or last reviewed for physical therapy. |
| 30 | Date outpatient speech pathology plan established or last reviewed | Indicate the date a plan of treatment for speech pathology was established or last reviewed |
| 35 | Date treatment started for PT | Indicate the date services were initiated for physical therapy. |
| 44 | Date treatment started for OT | Indicate when occupational therapy services were initiated. |
| 45 | Date treatment started for speech language pathology (SLP) | Indicate when speech language pathology services were initiated. |
| 50 | Date other insurance paid | Indicate the date the other insurance paid the claim. |
| 51 | Date claim filed with other insurance | Indicate the date the claim was filed to the other insurance. |
| 52 | Date renal dialysis initiated | Indicate the date the renal dialysis is initiated. |

Patient Discharge Status Codes

| Code | Description |
|------|--|
| 01 | Routine discharge |
| 02 | Discarded to another short-term general hospital for inpatient care |
| 03 | Discharged to SNF |
| 04 | Discharged to ICP |
| 05 | Discharged/transferred to a designated cancer center or children's hospital |
| 06 | Discharged to care of home health service organization |
| 07 | Left against medical advice |
| 08 | Reserved for national assignment |
| 09 | Admitted as an inpatient to the hospital (only for use on Medicare outpatient hospital claims) |
| 20 | Expired or did not recover |
| 30 | Still patient (To be used on when the client has been in the facility for 30 consecutive days if payment is based on (DRG) |
| 40 | Expired at home (hospice use only) |
| 41 | Expired in a medical facility (hospice use only) |
| 42 | Expired – place unknown (hospice use only) |
| 43 | Discharged/transferred to a federal hospital (such as a Veteran's Administration (VA) hospital or VA skilled nursing facility) |
| 50 | Hospice - Home |
| 51 | Hospice – Medical facility (includes patient who is discharged from acute hospital care but remains at the same hospital under hospice care) |
| 61 | Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed |

- 62 Discharged/transferred to Inpatient Rehabilitation Facility (IRF), including rehabilitation distinct part units of a hospital
- 63 Discharged/transferred to a Medicare Certified long-term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
 - > **Note:** Do not use when a patient is transferred to an inpatient psychiatric unit of a federal (VA) hospital. See Patient status Code 43 above.
- 66 Discharged/transferred to critical access hospital (CAH)
- 71 Discharged to another institution of outpatient services
- 72 Discharged to another institution

Coordination of Benefits

When a Medicare-Medicaid Plan member has other insurance benefits, the provider must bill the other insurance carrier prior to billing Cigna-HealthSpring. Within ninety-five (95) days of receipt of the primary payer's explanation of payment statement, the provider must file the claim with Cigna-HealthSpring.

Prior Authorization

The services that require prior authorization from Cigna-HealthSpring is listed in the Appendices of this provider manual. This list is also referenced on the provider tab on Cigna-HealthSpring's website at <http://starplus.cignahealthspring.com>. The list of Prior Authorization Services is intended to provide an overview of services requiring authorization. An authorization returned to a provider as "PA not required" is an effort to explain the item/service the provider is requesting is not on our requirement list. "PA Not Required" does not mean that service is approved or a guarantee of payment. If a Member requires a service that is not listed, the provider may contact Health Services to inquire about the need for prior authorization. The presence or absence of a procedure or service on the list does not determine a Member's coverage or benefits. If a provider renders services that require prior authorization without first obtaining prior authorization, then the claim will be denied. Note: A Prior Authorization is not a guarantee of payment.

Claims Payment

Cigna-HealthSpring processes professional and institutional Clean Claims, as defined by the Cigna-HealthSpring participating provider agreement, within thirty (30) days of receipt. Non-electronic pharmacy claims will be processed within twenty one (21) days and within fourteen (14) days of receipt of an electronic pharmacy claim by Cigna-HealthSpring's pharmacy vendor. Cigna-HealthSpring providers are reimbursed in accordance with their Cigna-HealthSpring participating provider agreements. Cigna-HealthSpring will pay Provider interest at a rate of 1.5% per

month (18% per annum) on all clean claims that are not adjudicated within thirty (30) days.

Electronic Funds Transfer

Cigna-HealthSpring has contracted with Change Healthcare (formerly Emdeon) to deliver electronic funds transfer (EFT) services.

If you are an existing EFT member with Change Healthcare (formerly Emdeon) and wish to add Cigna-HealthSpring to your service, please call **1-866-506-2830** and select Option 1 to speak with an Enrollment Representative.

If you would like to learn more or sign up for EFT, please visit Change Healthcare's (formerly Emdeon) ePayment Web site at <http://www.emdeonepayment.com> where you will be able to:

- > Learn more about the EFT service offering
- > Check out Change Healthcare's (formerly Emdeon) Payer List to see all available EFT-enabled payers
- > Obtain the EFT enrollment forms
- > Register for Online EFT Enrollment and Account Management Access
- > Electronic Remittance Advice (ERA)
- > Providers who are able to automatically post 835 remittance data will save posting time and eliminate keying errors by taking advantage of 835 ERA file service.

ERA Enrollment Process

Download Change Healthcare (formerly 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 Change Healthcare (formerly Emdeon) ERA Group:

- > Email: batchenrollment@emdeon.com
- > Fax: **1-615-885-3713**

Any questions related to ERA Enrollment or the ERA process in general, please call Change Healthcare

(formerly Emdeon) ePayment Solutions at **1-866-506-2830** for assistance

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

Claim Status and Resolution of Claims Issues

Provider Services can assist providers with questions concerning eligibility, benefits, claims and claims status. To check claims status, providers can call the Provider Services Department at **1-877-653-0331** or access the Provider Portal at <https://starplus.hsconnectonline.com>. If a claim needs to be reprocessed for any reason, Provider Services will coordinate reprocessing with the Claims Department.

Overpayments

An overpayment can be identified by the provider or Cigna-HealthSpring. If the provider identifies the overpayment, they can either submit a refund check all with an explanation of refund and/or Explanation of Payment (EOP) to Cigna-HealthSpring or they can call Provider Services at **1-877-653-0331** and approve a recoupment from any future payments to the provider. If Cigna-HealthSpring identifies the overpayment, a recovery letter will be sent to the provider, the provider has 45 days to submit a refund check or appeal the refund request. If the provider doesn't respond within 45 days from the date of the recovery letter, then recoupment will begin on any future payments. Refund checks along with explanation of refund can be sent to:

Cigna-HealthSpring Finance Department
Attn: Medicare-Medicaid Plan Service Operations
2900 North Loop West, Ste 1300
Houston, TX 77092

Claims Appeals

An appealed claim is a claim that has been previously adjudicated as a Clean Claim and the provider is appealing the disposition through written notification to the Managed Care Organization. When submitting claims please follow the guidelines listed below:

- > Providers must request Claim Appeals within 60 days from the date of remittance of the Explanation of Payment (EOP).
- > Providers may fax written Claims Appeals to **1-877-809-0783** or mail them to:
Cigna-HealthSpring
Appeals and Complaints Department
P.O. Box 211088
Bedford, Texas 76095

In the event that Cigna-HealthSpring requires additional information to process an appeal, the provider must return requested information within twenty-one (21) days from

the date of Cigna-HealthSpring's request. If the requested information is not received within this time, the case will be closed. A Claim Appeal Form is located on our provider website as well as the Appendices that list the information that we would like to receive in order to process your Appeal correctly. For example:

- > Claim Number
- > Date of service
- > Member Name
- > Medicaid or Medicare ID #
- > The reason or basis for the appeal

An acknowledgement letter is sent within five (5) business days of receiving a provider's written Claim Appeal. Provider Claim Appeals are resolved within thirty (30) days of receipt of the Claim Appeal. Cigna-HealthSpring sends written notification of the resolution to the provider.

Note: A corrected claim is not an appeal.

Corrected Claims Process

You can submit a corrected claim either electronic or paper format.

When submitting a corrected claim on a CMS 1500, the claim must clearly be marked as "Corrected Claim" along with the original claim number in box 22 form along with resubmission code of 7. When submitting a corrected claim on a UB 04, the claim must clearly be marked as "Corrected Claim" along with the third digit of Type of Bill indicated as Frequency code 7.

Corrected claims must be sent within 60 days of initial claim disposition. Failure to mark the claim as Corrected could result in a duplicate claim and be denied for exceeding the 95 days timely-filing deadline.

Payment Disputes

A payment dispute is a written communication (i.e. a letter) from the Provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records. This form may also be used for a nursing facility RUG level change. To check claims status, providers can call the Provider Services Department at **1-877-653-0331**.

The documentation must also include a description of the reason for the request.

- > Indicate "Payment dispute of (original claim number)"
- > Include a copy of the original Explanation of Payment
- > Unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim.

Reasons of when to use the payment dispute form:

- Denial for “timely filing”, but provider has proof of timely
- Denial for “no authorization on file”, but provider has authorization listed
- Denial for “benefit not covered”, but per TMHP it is payable
- Denial for “no coverage”, but member was active during the Date of Service (DOS)
- Provider not being paid at correct reimbursement rate, paid incorrectly
- Denial for incorrect modifier, CPT code, National Drug Code (NDC) number, NPI/TIN/TPI, Place of Service (POS), Date of Service (DOS), Type of Bill (TOB), Diagnosis (DX) code, etc. and denied incorrectly
- Denial for “no active provider contract” and provider does have an active contract listed
- Denial for insufficient units, per authorization on file there’s units available, or there’s no units available due to error on our end
- Denial for “bundled services”, per NCCI (National Correct Coding Initiative) edits they should not be bundled
- Denial for incorrect payment
- Denial for physician assist (PA), but per guidelines it should be allowed and payable
- Denied for “acute services need to be billed to primary insurance”, per member’s eligibility might be covered under their LTSS benefits
- Denial with no reason
- Denial for “benefit not covered out of network”, but member was at the hospital for inpatient/outpatient stay and a NON-PAR doctor saw the member while hospitalized and provider billed with correct POS, TOB and CPT codes
- Denial for “no member match” but the member was active for DOS, and DOB, ID and name all match the original submission
- Denial for “service included within the visit rate,” but paid nothing on the claim and there is no duplicate listed

The Payment Dispute Form can be found on our website <http://starplus.cignahealthspring.com>. A sample of this form can be seen in the Appendices of this provider manual. Providers can fax the Payment Dispute Form to 1-877-809-0783, e-mail to Claims_MMP_Medicaid@HealthSpring.com or mail to:

Attention: Cigna-HealthSpring Payment Dispute Unit

P.O. BOX 211088

Bedford, TX 76095

Balance Billing

Participating Cigna-HealthSpring providers are prohibited from balance billing Medicare-Medicaid Plan members including, but not limited to, situations involving non-payment by Cigna-HealthSpring, insolvency of Cigna-HealthSpring, or Cigna-HealthSpring’s breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against members or persons, other than Cigna-HealthSpring, acting on behalf of members for covered services provided pursuant to the Cigna-HealthSpring participating provider agreement. The provider is not, however, prohibited from collecting copayments, co-insurances or deductibles for non-covered services in accordance with the terms of the applicable member’s benefit plan.

In the event that a provider refers a member to a non-participating provider without prior authorization from Cigna-HealthSpring, if required, or provides non-covered services to a member, the provider must inform the member in advance, in writing: (i) of the service(s) to be provided; (ii) that Cigna-HealthSpring will not pay for or be liable for said service(s); and (iii) that the member will be financially liable for such services. In the event the provider does not comply with the requirements of this section, the provider shall be required to hold the member harmless as described above.

Cigna-HealthSpring will initiate and maintain any action necessary to stop a network provider or employee, agent, assign, trustee or successor-in-interest of network provider from maintaining an action against HHSC, an HHS agency or any member to collect payment from HHSC, an HHS agency or any member above an allowable copayment or deductible, excluding payment services not covered by MMP.

If a Cigna-HealthSpring member decides to go to an out-of-network provider or chooses to get services that have not been authorized or are not a covered benefit, the member must document his/her choice by signing the Member Acknowledgement Statement provided in the Appendices of this manual. Once the member signs a member Acknowledgment Statement, the provider may bill the member for any service that is not a benefit under Cigna-HealthSpring or the Medicare-Medicaid Plan.

Private Pay Agreement

If a member elects to be a “private pay” patient, the provider must advise member at the time of service that he/she is responsible for paying for all services received. The provider should require the member to sign the Private Pay Form

provided in the Appendices of this manual. This documents that the member has been properly notified of the private pay status. Providers are allowed to bill members as private pay patients if retroactive Medicare-Medicaid eligibility is not granted. If the member becomes eligible retroactively, the member must notify the provider of the change in status. The provider must refund money paid by the member and file claims to the appropriate payer for all services rendered. Ultimately, the provider is responsible for filing Medicare-Medicaid Plan claims in a timely manner.

Claim Filing Tips

- If two identical claims are received for the same service on the same date for the same member, one of the claims will be denied as an 'exact' duplicate; unless noted as a corrected claim. Please see Section Corrected Claims Process.
- For CMS 1500 claims, each separate date of service must be itemized on its own line
- The correct Cigna-HealthSpring member ID number must be on the claim
- Use only valid procedure codes by consulting the current CPT® book, HCPCS Manual and/or the LTSS HCPCS Codes and Medicare-Medicaid Plan Modifiers Matrix. CPT® books are available at most book stores or they can be ordered by contacting the American Medical Association at **1-312-464-5000** or toll free at **1-800-621-8335**. ICD-10-CM diagnosis code books can be found at most bookstores or by contacting the American Hospital Association at **1-312-422-3000** or toll free at **1-800-424-4301**.
- When using a modifier, whether from Appendices of the CPT manual or as required by TMHP manual, place it immediately following the 5-digit procedure code. Do not insert a space or a dash.
- CMS 1500 claim forms may be obtained at many bookstores or by contacting the American Medical Association at **1-312-464-5000** or toll free at **1-800-621-8335**.
- Claims should be submitted for one member and one provider per claim form.
- Multiple visits rendered over several days should be itemized by date of service.
- Personal attendant services should be billed in full unit.
- Claims for newborn members should be filed to the correct STAR or STAR+PLUS MCO.
- Unlisted procedures codes should be submitted only when a specific code to describe the service is not available or when indicated in the contract. Submit these codes with a complete description indicated on the CMS 1500 form.
- Providers who bill multiple units of the same procedure code should use the unit column on the CMS 1500 form.
- Assistant surgical procedures must be billed with modifiers 80, 81, 82, or AS
- Anesthesia procedures must be billed modifiers AA, AD, QK, QS, QX, QY, or QZ; and Modifier U1 or U2 as appropriate from TMHP manual.
- Professional components of laboratory, radiology or radiation therapy procedures must be billed with modifier 26.
- Technical components of laboratory, radiology or radiation therapy procedures must be billed with modifier TC. The following procedures do not require a modifier and are automatically processed as a technical component:
 - 77401; 77402; 77403; 77404; 77406; 77407; 77408; 77409; 77411; 77412; 77413; 77414; 77416; 77417
 - 93005; 93017; 93041;
 - 93225; 93226; 93231; 93232; 93236; 93721
- Providers billing as a group must list the:
 - Rendering provider's NPI in the un-shaded portion of box 24j
 - Rendering provider's TPI in the shaded portion of box 24j
 - Group provider's NPI in box 32a
 - Group's TPI in box 32b
- Providers should list only one authorization number per claim form.
- Providers need to bill the required National Drug Code (NDC) for certain HCPCS procedure codes. Reference the following website for the NDC/HCPCS crosswalk and additional information: **www.dmepdac.com/crosswalk/index.html**
- Providers billing on a UB-04 should only bill with a patient status 30 (box 17) when the member is inpatient
- CMS 1500 claims must be billed with a valid place of services identifier

Sample of Explanation of Payment (EOP)

P8790028000



2900 N. Loop West
Ste. 1300
Houston, TX 77092

201306210113

Forwarding Service Requested

11637 0_5486 AT 0_381 3-DIGIT 785

Smith, John
PO BOX 4587
Mission, TX 78573-4587

52

Contact Provider Services with any questions
1- (877) 653-0331
Monday - Friday 8:00 am to 5:00 pm

Cigna-HealthSpring
Claims Department
PO Box 981709
El Paso, TX 79998-1709



1 OF 2

ENV 11637

Date: 09/20/2013
Vendor: Smith, John
NPI: #####
Voucher Number: 801019
Check ID:
Check Number: 801019

Explanation of Payment

| | | |
|------------------------------|-----------------------------------|-----------------------------------|
| Medicaid ID: ##### | Plan: STAR+PLUS Hidalgo | Provider Acct No: 458741 |
| Member Name: Jane Doe | Claim Number: 587654E47896 | Provider Name: Smith, John |

| From Date of Service | To Date of Service | Service Code | Billed Amount | Allowed Amount | Copay Coinsurance | Deductible | Adjustment | Interest | Payment | Reason Code |
|----------------------|--------------------|--------------|---------------|----------------|-------------------|------------|------------|----------|---------|-------------|
| 09/06/2013 | 09/06/2013 | 99213 | 165.00 | 33.27 | 0.00 | 0.00 | 131.73 | 0.00 | 33.27 | |
| Claim Totals: | | | 165.00 | 33.27 | 0.00 | 0.00 | 131.73 | 0.00 | 33.27 | |

| | | | | | | | |
|-----------------------|--------|-------|------|------|--------|------|-------|
| Vendor Totals: | 165.00 | 33.27 | 0.00 | 0.00 | 131.73 | 0.00 | 33.27 |
|-----------------------|--------|-------|------|------|--------|------|-------|

Remark Code Explanation

- 901 \$0.00 Beginning balance from recovery amounts
- 902 \$0.00 Recovery amounts applied to this check
- 903 \$0.00 Check(s) received from provider for this check period
- 904 \$0.00 Amount Written Off
- 905 \$0.00 Outstanding balance not yet applied
- *** Claims appeals must be submitted in writing within 60 calendar days from the date of your Remittance or Explanation of Payment (EOP).



2900 N. Loop West Ste. 1300
Houston, TX 77092

65-7293
2550

CHECK NO.: 0801019
CHECK DATE: 09/20/2013

PAY Thirty Three & 27/100 Dollars

TO THE Smith, John
ORDER OF PO Box 4587

Mission, TX 78573-4587

Amegy Bank
San Antonio, TX 78229

| AMOUNT |
|-------------|
| ***** 33.27 |

VOID

PROVIDER RESPONSIBILITIES

Cigna-HealthSpring recognizes and values each provider's immeasurable contributions to the Medicare-Medicaid Plan. Without a dedicated team of health care providers, Cigna-HealthSpring could not successfully deliver on its goal of improving access to care, quality of care, and member satisfaction. To ensure providers have access to all resources and tools needed to support Cigna-HealthSpring members, Cigna-HealthSpring employs a Provider Services team to assist providers when daily operations do not go as planned. The Provider Services team is available to assist providers with general questions and/or schedule educational in-services with the provider's office if needed. Providers can reach the Cigna-HealthSpring Provider Services Department by calling **1-877-653-0331**. In order to ensure a successful partnership with Cigna-HealthSpring, providers should familiarize themselves with all sections of the Cigna-HealthSpring provider manual, including the following Cigna-HealthSpring important participation requirements.

Communication Among Providers

It is essential that Cigna-HealthSpring providers communicate with each other to ensure appropriate and timely member access to care. When referring members for care, PCPs should provide physical health and/or Behavioral Health providers with all relevant clinical information regarding the member's care, including the results of any diagnostic tests and laboratory services. Specialty physician providers should forward to the member's PCP a summary of all visits, clinical findings, and treatment plans. PCPs should document this information appropriately in the member's medical record.

Provider Access and Availability Standards

After Hours Accessibility

Cigna-HealthSpring PCPs and Specialty Care Providers (SCP) are required to maintain after-hours call coverage to ensure members have access to care twenty-four (24) hours per day, seven (7) days per week. The following are acceptable and unacceptable phone arrangements for contacting PCPs or SCPs after normal business hours:

Acceptable After-hours Coverage:

- > Office telephone is answered after-hours by an answering service, which meets the language requirements of the provider's patient population, and can contact the provider or another designated provider. All calls related to patient care answered by an answering service must be returned within thirty (30) minutes.
- > Office telephone is answered after normal business hours by a recording, which meets the language requirements of the provider's patient population and directs the member to call another number to reach the provider or another provider designated by the PCP or SCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- > Office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, SCP or another designated provider. All calls related to patient care must be returned the call within thirty (30) minutes.

Unacceptable After-hours Coverage:

- > Office telephone is answered only during office hours
- > Office telephone is answered after-hours by a recording that tells members to leave a message
- > Office telephone is answered after-hours by a recording that directs members to go to an emergency room for services needed
- > Patient care related calls are not returned within thirty (30) minutes

Appointment Accessibility

All Cigna-HealthSpring providers are required to offer timely appointments to members as indicated in the following Appointment Availability Standards:

| Type of Appointment or Service | Timeframe |
|--------------------------------|---|
| Emergency services | Upon member presentation at the service delivery site, including at non-network and out-of-area facilities. |
| Urgent care appointments | Triaged and, if medically necessary or appropriate, including urgent specialty care, immediately referred for urgent Medically Necessary care or provided with an appointment within twenty-four (24) hours, regardless of weekend or business day. |

| Type of Appointment or Service | Timeframe |
|---|---|
| Routine primary care | Within fourteen (14) days for non-urgent, symptomatic condition. |
| Routine specialty care referrals | Within a timely basis, based on the urgency of the members medical condition, but no later than thirty (30) days of request for non-urgent, symptomatic condition. |
| Behavioral health | Initial outpatient behavioral health visits must be provided within 14 days. |
| Adult preventive health physicals and well visits for members over age 21 | Within ninety (90) days. |
| Prenatal care/ first visit | Within fourteen (14) days, except for high-risk pregnancies or new members in the third trimester, for whom an appointment must be offered within five (5) days or immediately, if an emergency exists. |
| Office waiting time | Within thirty (30) minutes of the scheduled appointment time. |

Demographic Changes

Cigna-HealthSpring providers should review the Cigna-HealthSpring Provider Directory, both printed and online, to ensure Cigna-HealthSpring maintains the most updated demographic information, i.e., physical address, claims payment remit address, phone and facsimile numbers, etc. Providers must notify Cigna-HealthSpring and HHSC's administrative services contractor in advance of any change in demographic information, preferably thirty (30) days prior to the effective date of the change.

The following types of demographic changes should be faxed to **1-877-440-7260** or emailed to

ProviderDataValidation@healthspring.com:

- > Tax identification number
- > Office address
- > Billing address
- > Telephone number
- > Changes in practice limits or office hours
- > Specialty
- > The departure of or addition of a new physician to an existing practice

Advanced Medical Directives

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

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

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

HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Coordination with Texas Department of Family and Protective Services (TDFPS)

Cigna-HealthSpring works with Texas Department of Family and Protective Services (TDFPS) to ensure that any pediatric members in custody or under the supervision of, TDFPS receive needed services. The needs of this population are special in that children will transition in and out of care more frequently than the general population. In addition, suspected abuse, neglect or exploitation of an adult with disabilities or an elderly person (aged 65 or older) should also be reported to the Texas Department of Family and Protective Services using the contact information below.

Cigna-HealthSpring requires that providers:

- Coordinate with TDFPS and foster parents for the care of a child who is receiving services from, or has been placed in the conservatorship of TDFPS, and respond to requests from TDFPS
- Provide medical records to TDFPS
- Provide periodic written updates on treatment status of members, as required by TDFPS
- The Provider must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS)
- Schedule appointments for medical and behavioral health services within fourteen (14) days unless requested earlier by TDFPS
- Refer suspected abuse and neglect to TDFPS by calling toll free at **1-800-252-5400** or by using the TDFPS secure website at <http://www.txabusehotline.org>

Cigna-HealthSpring must continue to provide all covered services to a member receiving services from, or in the protective custody of TDFPS until the member is placed into foster care or disenrolls from Cigna-HealthSpring due to loss of eligibility. If a provider is caring for a member in custody or under supervision of TDFPS, they are encouraged to contact the member's Service Coordinator for any care coordination needs.

Termination of Provider Contracts

A provider may terminate from the Cigna-HealthSpring network according to the Cigna-HealthSpring participating provider agreement which details the written notification timeframes and other termination provisions. If a provider agreement terminates, Cigna-HealthSpring will notify affected members in writing at least fifteen (15) days prior to the effective date of the termination. Affected members include all members in a PCP's panel and all members receiving

ongoing care from the terminated provider, where ongoing care is defined as two (2) or more visits for home-based or office-based care in the past twelve (12) months.

In the event that a member is receiving covered services at the time a provider agreement is terminated, the provider must continue to provide covered services until the treatment is completed. Once treatment is complete, Cigna-HealthSpring will coordinate the transition of care to another participating Cigna-HealthSpring provider.

Attendant Care Enhancement Program (ACEP)

Attendant Care Enhancement Program (ACEP)

Cigna-HealthSpring offers all eligible, Cigna-HealthSpring credentialed and contracted providers the opportunity to participate in the Cigna-HealthSpring STAR+PLUS Attendant Care Enhanced Payment (ACEP) Option which is based on funding by the Texas Legislature. To participate, providers must allocate at least 90% of the dollars received under this option to the Community Care Attendant(s) as stipulated in the rules outlined in Title 1, Texas Administrative Code (TAC) 355.112. Long Term Support Services (LTSS) providers who would like to participate in Cigna-HealthSpring's Attendant Care Enhancement Program (ACEP) may do so if they meet Cigna-HealthSpring's participation criteria.

How Cigna-HealthSpring Makes ACEP Payments

Cigna-HealthSpring will increase its fee schedules for eligible service codes for ACEP participants to include the provider's fee-for-service rate plus the ACEP rate. Providers must include appropriate modifiers required by the HHSC HCPCS Codes and STAR+PLUS Modifiers Matrix. To receive ACEP payments, providers must submit claims for services rendered in accordance with Cigna-HealthSpring's participating provider agreement and the Provider Manual. ACEP payments will be administered at the time claims are adjudicated.

How to Become an ACEP Provider

During the Enrollment Period providers who desire to participate in Cigna-HealthSpring's ACEP program must submit an attestation form. The Enrollment Period begins September 1st through October 31st (60 day enrollment period) every year. Providers who choose to participate must submit their current ACEP level set by HHSC during the Enrollment Period. The Enrollment Period is the only opportunity to modify your current ACEP level or participate as a new participant until the next Enrollment Period.

If an ACEP attestation is not received within the Enrollment Period, the ACEP level will be changed to zero. ACEP Provider Enrollment and Attestation form can be found on our website: <http://starplus.cignahealthspring.com/forms>.

All required information must be submitted in its entirety in order for any review to be conducted and completed by CHS. Please return form in one of the following ways:

- > Online at our Cigna-HealthSpring website:
<http://starplus.cignahealthspring.com/forms>
- > Fax to: 1-855-250-9862
- > US Mail: Business Support, Cigna-HealthSpring STAR+PLUS:
2208 Highway 121, Ste 210, Bedford, TX 76021

Participation Criteria

Cigna-HealthSpring's participation criteria for its ACEP program are:

- > Cigna-HealthSpring licensure to offer day activity and health services (DAHS), personal attendant services (PAS), Community First Choice (CFC) or assisted living/residential care services (AL/RC);
- > Active status as a participating provider in Cigna-HealthSpring's STAR+PLUS network;
- > Existing Cigna-HealthSpring participating agreement that outlines ACEP level;
- > Written agreement to abide by all terms and conditions of Cigna-HealthSpring's ACEP program as outlined in the Cigna-HealthSpring Provider Manual and the participating provider agreement;
- > No formal Member complaints regarding quality of care or service that resulted in corrective action.

Community First Choice Provider Responsibilities

Community First Choice (CFC) allows Provider to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. All CFC services will be provided in a home or community based setting, which does not include a nursing facility, hospital providing long-term services, institution for mental disease, an intermediate care facility for individuals with an intellectual disability or related condition, or a setting with the characteristics of an institution. Community First Choice Services include: help with activities of daily living and health-related tasks through hands-on assistance, supervision or cueing; services to help the individual learn how to care for themselves; backup systems or ways to ensure continuity of services and supports; training on how to select, manage and dismiss attendants.

- > The CFC services must be delivered in accordance with the Member's service plan.
- > Have current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC

services), medication administration record (if applicable), and nursing assessment (if applicable)

- > Must ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- > Ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.
- > Ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. (1-800-647-7418).
- > Address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- > The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- > The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.

- > For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- > Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- > The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- > Adhere to the Cigna-HealthSpring financial accountability standards.
- > Prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- > Prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

Selection". Forms are also located at <http://starplus.cignahealthspring.com/evv>

- > Provider EVV default process for non-selection
 - Mandated providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and/or will be defaulted to a selected vendor by HHSC. The provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.
- > When can a provider change EVV vendors?
 - A provider may change EVV vendors 120 days after the submission date of the change request.
 - A provider may change EVV vendors only twice in the life of their contract with the MCO. There are only two vendors.
 - A provider will submit an updated copy of the Provider Electronic Visit Verification Vendor System Selection form and select "Vendor Change" when requesting a change to another EVV Vendor.

Electronic Visit Verification (EVV)

What is EVV?

- > Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.
- > EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR+PLUS, STAR Kids, Medicare-Medicaid Plan (MMP), or Community First Choice Member's home to provide a service will document their arrival time, services and departure time using a telephonic application system. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to the MCO for targeted EVV services.

Do providers have a choice of EVV vendor?

- > Provider Selection of EVV vendor
 - During the contracting and credentialing process with an MCO, a copy of the Provider Electronic Visit Verification Vendor System Selection form should be provided in the application packet. A provider is required to use a HHSC-approved EVV vendor as listed on the selection form and select "Initial

Can a provider elect not to use EVV?

All Medicaid-enrolled service providers (provider agencies) who provide STAR+PLUS and CFC services that are subject to EVV are required to use a HHSC approved EVV system to record on-site visitation with the individual/member. Those services include:

- > Personal assistance services (PAS)
- > In-Home Respite
- > Community First Choice – PAS/Habilitation

Is EVV required for CDS employers?

No. CDS Employers have the option to choose from the following 3 options:

- > Phone and Computer (Full Participation): The telephone portion of EVV will be used by your Consumer Directed Services (CDS) Employee(s) and you will use the computer portion of the system to perform visit maintenance.
- > Phone Only (Partial Participation): This option is available to CDS Employers who can participate in EVV, but may need some assistance from the FMVA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS Employee will call-in when they start work and call-out when they end work. Your FMVA will perform visit maintenance to make the EVV system match your paper time sheet.

- > No EVV Participation: If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.

How do providers with assistive technology (ADA) needs use EVV?

If you use assistive technology (ADA), and need to discuss accommodations related to EVV system or materials, please contact the HHSC-approved EVV vendors below:

- > DataLogic (Vesta) Software, Inc. Contact:
 - Sales & Training
Email: info@vestaevv.com
Phone: (888) 880-2400
 - Tech Support
Email: support@vesta.net
Phone: (888) 880-2400
 - Website: www.vestaevv.com
- > MEDsys Software Solutions, LLC Contact:
 - Texas Dedicated Support and Sales Number
Email: Sales: info@medsyshcs.com
Phone: Support: (877) 698-9392; Option 1
Phone: Sales: (877) 698-9392; Option 2
 - Website: www.medsyshcs.com

EVV use of small alternative device (SAD) and required SAD forms

The SAD process can be found at:

- > <http://www.dads.state.tx.us/evv/formshandbooks.html>
- > SAD forms can be found at:
<http://starplus.cignahealthspring.com/evv>
- > Where do I submit the SAD agreement/order form?
 - The form is submitted to the provider selected EVV vendor
 - DataLogic – email form to: tokens@vestaevv.com or send secure efax to 956-290-8728
 - Medsys – email form to: tokens@medsyshcs.com or send secure efax to 888-521-0692
- > Equipment provided by an EVV contractor to a Provider, if applicable, must be returned in good condition.

What is the HHSC Compliance Plan?

- > The HHSC Compliance Plan is a set of requirements that establish a standard for EVV usage that must be adhered to by Provider Agencies under the HHSC EVV initiative.

- > Provider Agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90 percent per Review Period. Reason Codes must be used each time a change is made to an EVV visit record in the EVV System

EVV Compliance

All providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- > The Provider must enter Member information, Provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual process. The provider agency must ensure that all required data elements, as determined by HHSC, are uploaded or entered into the EVV system completely and accurately upon entry, or they will be locked out from the visit maintenance function of the EVV system.
- > The Provider must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- > The Provider Agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- > The Provider Agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- > Providers should notify the appropriate MCO, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
- > Provider Agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Provider Agencies must submit claims in accordance with their contracted entity claim submission policy. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted on a case-by-case basis.
- > Provider agencies must use the reason code that most accurately explains why a change was made to a visit record in the EVV System. The MCOs, will review reason code use by their contracted provider agencies to ensure that preferred reason codes are not misused.
- > If it is determined that a provider agency has misused preferred reason codes, the provider agency HHSC

EVV Initiative Provider Compliance Plan Score may be negatively impacted, and the provider agency may be subject to the assessment of liquidated damages, imposition of contract actions, implementation of the corrective action plan process, and/or referral for a fraud, waste, and abuse investigation.

- Provider agencies must ensure that claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System
- Claims are subject to recoupment if they are submitted before all of the required visit maintenance has been completed in the EVV System.
- Claims that are not supported by the EVV system will be subject to denial or recoupment.
 - With the exception of HHSC-identified Displaced CM2000 providers, all provider agencies must use the EVV system as the system of record by September 1, 2015.
 - HHSC-identified Displaced CM 2000 providers must use the EVV system as the system of record by February 1, 2015.
- Adherence to Provider Compliance Plan
 - The MCO Compliance Plan at <http://starplus.cignahealthspring.com/evv>
 - The HHSC Compliance Plan is located at: <https://www.dads.state.tx.us/evv/complianceplans.html>
 - HHSC EVV Initiative Provider Compliance Plan – A set of requirements that establish a standard for EVV usage that must be adhered to by Provider Agencies under the HHSC EVV initiative.
 - Provider Agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90 percent per Review Period. Reason Codes must be used each time a change is made to an EVV visit record in the EVV System
- Any Corrective action plan required by an MCO is required to be submitted by the Network Provider to the MCO within 10 calendar days of receipt of request.
- MCO Provider Agencies may be subject to termination from the MCO network for failure to submit a requested corrective action plan in a timely manner.

EVV Complaint Process

Please see section on “Provider Complaints to Cigna-HealthSpring”

EVV Refusal Process

As part of §354.1177 under Title 1, Part 15, Chapter 354, subchapter A, Division 11, all contracted providers that provide EVV services are required to use an EVV system for services as defined by HHSC.

There is no cost to providers for access and use of the selected EVV vendor system. Per HHSC’s agreement with each MCO and each selected EVV vendor, there will be no cost passed onto the provider for defined services as required by the HHSC contract. Should an EVV vendor offer services in addition to the state’s defined service requirements, those may be purchased by providers at their discretion and cost.

Providers of Home Health Services Responsibilities

- Provider Compliance Plan (excluding Consumer-Directed Services (CDS))
 - http://www.dads.state.tx.us/evv/complianceplan/HHSC_EVV_Provider_Compliance_Plan.pdf
 - Non-CDS EVV providers must adhere to the Provider Compliance plan found at <http://starplus.cignahealthspring.com/evv> or by contacting Cigna-HealthSpring at 1-877-653-0331 for the most current version.
 - When a change is made to a visit in the EVV system, a reason code must be entered to provide the MCO information regarding the reason for the change made to the record. Some reason codes will require providers to enter a comment to provider further information. Reason codes fall under two categories: Preferred Reason Codes and Non-preferred reason codes. A preferred reason code is a code that documents visit maintenance necessitated by a situation in which the provider staff are delivering and documenting services in accordance with Cigna-HealthSpring’s expectations. A non-preferred reason code is a code that documents visit maintenance that is necessitated by a situation in which the provider staff is not delivering and documenting services in accordance with Cigna-HealthSpring’s expectations. Providers and CDS employers must use the appropriate reason code(s) with each change made in visit maintenance.

Training

Each vendor is required to train providers selecting their system on the system’s use and capabilities. Cigna-HealthSpring will also provide training on our program’s compliance and monitoring of the provider’s use of the EVV system. For training information you can refer to our Provider website at <http://starplus.cignahealthspring.com>.

Claim payments

Providers must adhere to the EVV guidelines in the Provider Compliance plan when submitting a claim. Claim payments will be affected by the use of EVV. Cigna-HealthSpring is required to ensure each PAS, and PCS service unit authorized and billed to Cigna-HealthSpring matches the applicable EVV record. Cigna-HealthSpring will evaluate the claim and EVV record on a regular basis. Any discrepancy may result in the claim being denied or recouped.

Claims must be submitted within 95 calendar days of the EVV visit.

Questions or assistance

If you need further assistance with the EVV system, please contact your vendor. If you need to contact Cigna-HealthSpring, please call us at 1-877-653-0331 or visit our website for additional information at <http://starplus.cignahealthspring.com>.

Cigna-HealthSpring Provider Compliance and Waste, Abuse, and Fraud Policy

Cigna-HealthSpring's Compliance Program monitors compliance with federal and State laws, including health care waste, abuse, and fraud statutes and regulations. The Compliance Program is designed to prevent violations of federal and State laws. In the event violations occur, the Compliance Program promotes early and accurate detection, prompt resolution and disclosure to governmental authorities, when appropriate.

Cigna-HealthSpring expects all contracted providers to be ethical and compliant. Cigna-HealthSpring encourages its own employees as well as each provider's employees, contractors, and other parties to report suspected violations of law and policy, without fear of retribution.

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- > Getting paid for services that weren't given or necessary.
- > Not telling the truth about a medical condition to get medical treatment.
- > Letting someone else use their Medicaid or CHIP ID.
- > Using someone else's Medicaid or CHIP ID.
- > Not telling the truth about the amount of money or resources he or she has to get benefits.

Reporting Waste, Abuse or Fraud by a Provider or a Client

Reports may be filed in the following manner:

- > To report suspected or detected Medicare or Medicaid program non-compliance please contact Cigna-HealthSpring's Compliance Department at:
Cigna-HealthSpring
Attn: Compliance Department
9009 Carothers Parkway, Suite B-100
Franklin, TN 37067
 - > To report potential fraud, waste, or abuse please contact Cigna-HealthSpring's Benefit Integrity Unit at:
 - By mail:
Cigna-HealthSpring
Attn: Benefit Integrity Unit
500 Great Circle Road
Nashville, TN 37228
 - By phone:
1-800-230-6138
Monday through Friday
8:00 AM to 6:00 PM CST
 - Visit:
<http://oig.hhsc.state.tx.us/>
Under the box labeled "I WANT TO" click "Report Waste, Abuse and Fraud" to complete the online form. The site tells you about the types of waste, abuse and fraud to report. If you would rather talk to a person, call the HHSC Office of Inspector General Fraud Hotline (OIG) at **1-800-436-6184**.
 - > You can also send a note or letter to the following addresses:
 - To report **Providers**, use this address:
Office of Inspector General Medicaid Provider Integrity/Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200
 - To report **Members**, use this address:
Office of Inspector General
General Investigations/Mail Code 1362
P.O. Box 85200
Austin, TX 78708-5200
- To report waste, abuse or fraud, gather as much information as possible.
- When reporting about a provider (a doctor, dentist, counselor, etc.) include the:
- > Name, address, and phone number of provider
 - > Name and address of the facility (hospital, nursing home, home health agency, etc.)
 - > Medicaid number of the provider and facility, if you have it

- > Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- > Names and phone numbers of other witnesses who can help in the investigation
- > Dates of events
- > Summary of what happened

When reporting about someone who receives benefits, include:

- > The person's name
- > The person's date of birth, Social Security number, or case number if you have it
- > The city where the person lives
- > Specific details about the waste, abuse or fraud

Provider Complaint and Appeal Process

Cigna-HealthSpring is committed to providing excellent service to its participating providers. In the event a provider feels Cigna-HealthSpring is falling short of this goal, he/she should contact the Provider Services Department immediately by calling 1-877-653-0331. Provider Services is available to assist providers with their concerns at any time.

Definitions Overview

A **Complaint** means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. As provided by 42 C.F.R. 438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid member's rights.

An **Action** means:

- > The denial or limited authorization of a requested Medicaid service, including the type or level of service
- > The reduction, suspension, or termination of a previously authorized service
- > The denial in whole or in part of payment for service
- > The failure to provide services in a timely manner
- > The failure of an MCO to act within the timeframes set forth in the Contract and 42 C.F.R 438.408(b)
- > For a resident of a rural area with one MCO, the denial of a Medicaid member's request to obtain services outside of the network
- > An Adverse Determination is one type of Action.

An **Appeal** is a formal process by which a member or his or her representative requests a review of the MCO's Action as defined above.

An Authorized Representative is any person or entity acting on behalf of the member, from whom Cigna-HealthSpring has received the member's written consent. A provider may be an authorized representative.

A **Provider Claim Appeal** is a claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification to Cigna-HealthSpring in accordance with the Provider Claim Appeal Process as defined in the Cigna-HealthSpring provider manual.

Provider Complaints to Cigna-HealthSpring

Provider Complaints can be filed verbally or in writing by contacting Cigna-HealthSpring as follows:

- > Cigna-HealthSpring Appeals & Complaints Department
- By mail:
 - Cigna-HealthSpring**
 - Appeals & Complaints Department**
 - P.O. Box 211088**
 - Bedford, TX 76095**
- By fax: **1-877-809-0783**
 - > Cigna-HealthSpring Provider Services Department
- By phone: **1-877-653-0331**
Monday to Friday, 8 a.m. to 5 p.m. Central Time

If a provider Complaint is received verbally, Cigna-HealthSpring's Provider Services Representatives collect detailed information about the Complaint and route the Complaint electronically to the Appeals and Grievances Complaint Department for handling. Within five (5) business days from receipt of a Complaint, Cigna-HealthSpring will send an acknowledgement letter to the provider. Cigna-HealthSpring will resolve the Complaint within thirty (30) days from the date the Complaint was received by Cigna-HealthSpring. Providers must retain documentation of fax cover pages, emails to and from Cigna-HealthSpring and logs of telephone communication.

Provider Claims Appeals to Cigna-HealthSpring

Providers must request Claim Appeals within 60 days from the date of remittance of the Explanation of Payment (EOP). Providers may fax, mail or submit written Claims Appeals to:

- > Cigna-HealthSpring Appeals & Complaints Department
- By mail:
 - Cigna-HealthSpring**
 - Appeals & Complaints Department**
 - P.O. Box 211088**
 - Bedford, TX 76095**
- By fax: **1-877-809-0783**
 - > Cigna-HealthSpring Provider Portal

- Log into HS Connect to access our Claims portal:
<https://starplus.hsconnectonline.com>

An acknowledgement letter is sent within five (5) business days of receiving a provider's written Claim Appeal. In the event that Cigna-HealthSpring requires additional information to process an appeal, the provider must return requested information within twenty-one (21) days from the date of Cigna-HealthSpring's request. If the requested information is not received within this time, the case will be closed. Provider Claim Appeals are resolved within thirty (30) days of receipt of the Claim Appeal. Cigna-HealthSpring sends written notification of the resolution to the provider. Providers must retain documentation of fax cover pages, emails to and from Cigna-HealthSpring and logs of telephone communication.

Provider Complaints to HHSC

Providers may file a Complaint with HHSC. Complaints to HHSC must be received in writing and sent to the following address:

**Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services**

Providers who have access to the Internet can email complaints HPM_Complaints@hhsc.state.tx.us.

REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE)

Report suspected Abuse, Neglect, and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
- Adult day care centers; or
- Licensed adult foster care providers

Contact DADS at 1-800-647-7418.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
 - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
 - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
 - a managed care organization;
 - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).

- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

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

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:
Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

QI Department Functions

Cigna-HealthSpring is committed to providing access to quality health care through continuous study, implementation, and improvement. QI assumes no permanent threshold for good performance. As such Cigna-HealthSpring members should expect a comprehensive, therapeutic health care delivery system that is always evolving and improving. Cigna-HealthSpring's QI Department accomplishes this by integrating, analyzing, and reporting data from across the health plan as well as from other data sources. The QI Department prioritizes quality initiatives based on health plan relevance. Then, the QI Department works with internal departments to manage resources effectively, maximizing member health outcomes. On a quarterly basis Cigna-HealthSpring submits the number of Service Coordinators that received CDS training to HHSC. On a quarterly basis Cigna HealthSpring submits a number of critical incidents and abuse reports for members receiving LTSS services to HHSC.

Providers who have questions about Cigna-HealthSpring's QI Program, would like a QI Program description and list of continuously evolving goals, or a list of QI Program activities can contact Cigna-HealthSpring's QI Department at:

Cigna-HealthSpring
Medicare-Medicaid Plan
Attn: Quality Improvement Department
2208 Highway 121, Suite 210
Bedford, TX 76021

QUALITY MANAGEMENT

Overview

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

Quality Improvement Committee (QIC)

The Quality Improvement Committee (QIC) is responsible for the overall design and implementation of Cigna-HealthSpring's QI Program, as well as for the oversight of QI activities carried out by other committees. The QIC reports Corporate Quality Improvement Committee (CQIC) which in turn reports to the Board of Directors. The QIC ensures that all QI tasks and functions include member and provider involvement and that

they are conducted in compliance with all applicable regulatory and accreditation requirements.

Clinical Practice Guidelines

Cigna-HealthSpring's practice guidelines are based on evidence-based, clinical findings. These practice guidelines are reviewed and updated annually by the Provider Advisory Committee (PAC.) New guidelines are added to meet member needs and changes in membership. The clinical practice guidelines, which are available on Cigna-HealthSpring's website, <http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/index.html>, are based on resources such as:

| Resource | Website |
|--|---|
| American Heart Association | http://www.americanheart.org |
| American College of Cardiology | http://www.acc.org |
| American Medical Association | http://www.ama-assn.org |
| American Diabetes Association | http://www.professional.diabetes.org |
| Global Initiative for Chronic Obstructive Lung Disease | http://www.goldcopd.com |
| American Academy of Pediatrics | http://www.aap.org |
| National Institute for Health And Clinical Excellence (NICE) | http://www.nice.org |
| American Academy of Family Physicians | http://www.aafp.org |
| U.S. Preventive Services Task Force | http://www.uspreventiveservicestaskforce.org |

Healthcare Plan Effectiveness Data and Information Set (HEDIS®)

Healthcare Plan Effectiveness Data and Information Set (HEDIS®) is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS® measurements enable comparison of performance among managed care plans. The sources of HEDIS® data include administrative data (claims/encounters) and medical record review data. HEDIS® measurements related to the Medicare-Medicaid Plan include measures such as well-child visits, immunizations, appropriate use

of asthma medications, comprehensive diabetes care, and controlling high blood pressure.

Cigna-HealthSpring's HEDIS® measures are reported annually and represent a mandated activity for Medicare-Medicaid Plan MCOs. Each spring, Cigna-HealthSpring Representatives are required to collect copies of medical records from providers to establish HEDIS® scores. Selected provider offices will be contacted and requested to assist in these medical record collections. All records are handled in accordance with Cigna-HealthSpring's privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS® initiative, will be requested. HEDIS® is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule (see 45 CFR 164.501 and 506). Cigna-HealthSpring HEDIS® results are available upon request. To request information regarding those results, contact our Quality Improvement Department by mail at:

**Cigna-HealthSpring
Medicare-Medicaid Plan
Attn: Quality Improvement Department
2208 Highway 121, Suite 210
Bedford, TX 76021**

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

On-Site Assessments

Cigna-HealthSpring conducts on-site provider assessments in response to a member Complaint to assess the quality of care and services provided. During an on-site visit, Cigna-HealthSpring may assess the following items:

- > Physical appearance and accessibility
- > Member safety and risk management
- > Medical records organization, maintenance and storage
- > Appointment availability
- > Security of Information

Depending on the provider type or nature of the complaint, either a provider network representative or nurse will conduct the site review. Each section of the Site Evaluation Form addresses a review topic with questions to be answered "YES", "NO", or "N/A" (not applicable). Each answer is scored, and scores are added to generate an overall score for the office site. Results of the site review shall be reported directly to the provider that was subject to the review. Objective findings and recommendations for improvement of deficiencies shall be included in the report. Any provider scoring below eighty percent (80%) will be given thirty (30) days to submit and ninety (90) days to complete a corrective action plan. Upon completion of the corrective action plan, a repeat office site review will be performed. The completed Site Evaluation

Form will be placed in the provider's Credentialing and Quality of Care file for review by the Credentialing Committee.

Medical Record Requirements

Providers shall keep members' medical records confidential in compliance with State and federal laws regarding confidentiality of medical records. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. However, nothing shall limit timely dissemination of such records to authorized providers and consulting physicians, to governmental agencies as required and permitted by law, to accrediting bodies, to committees of provider, and to Cigna-HealthSpring for administrative purposes. To the extent permitted by law, Cigna-HealthSpring shall have the right to inspect at all reasonable times any medical records maintained by provider pertaining to Cigna-HealthSpring members. A provider agrees to maintain all medical records pertaining to treatment of members for a period of ten (10) years or, for minors, ten years past the attainment of age 21 years.

Medical Records shall not be removed or transferred from a provider except in accordance with general provider policies, rules, and regulations. Providers agree to furnish members timely access to their own records. Cigna-HealthSpring may audit a provider's medical records for Cigna-HealthSpring members, as a component of Cigna-HealthSpring's quality improvement, credentialing, and re-credentialing processes. In accordance with AMA guidance and NCQA guidelines, medical records must be legible with current details organized and comprehensive in order to facilitate the assessment of the appropriateness of care rendered. Documentation audits are performed to assure that PCPs and high-volume Specialty Care Providers maintain a medical record system that permits prompt retrieval of information. Audits are also performed to assure that medical records are legible, contain accurate and comprehensive information, and are readily accessible to health care providers. Medical record review also provides a mechanism for assessing the appropriateness and continuity of health care services. Applicable regulations mandate medical record review by Cigna-HealthSpring. Criteria (indicators) to be evaluated include the following:

- Demographic/personal data are noted in the record, complete member name, date of birth, home address and phone number, sex, marital status, insurance, and member identification number
- An emergency contact person's names, address, and phone number, or that there is no contact person is noted in the medical record
- Each page of the medical record contains the member's name or member identification number
 - All entries are legible, signed and dated by the author and include credentials and title. Signature may be handwritten, stamped, or electronic
- Significant illness, medical and psychological conditions are indicated on the problem/medical list and are listed in the front of the medical record
- Prescribed medications, including dosage, date of initial and/or refill prescriptions are listed
- There is evidence of member/caregiver education including medication review with every visit
- Allergies and adverse reactions to medications are prominently noted in the record
- The history and physical examination records indicate subjective and objective information pertinent to the member's presenting complaints
- Past medical history, including serious accidents, surgeries and illnesses are noted in the medical record
- Working diagnoses are consistent with the findings
- Treatment plans are consistent with the diagnosis and are noted in every visit note
- There is documentation that the member participated in the formulation of the treatment plan
- All diagnostic and therapeutic services for which a member was referred by a provider are in the medical record and there is evidence that the provider reviewed these reports
- There is explicit notation in the medical record of follow-up plans related to consultation, abnormal laboratory, and imaging study results
- Chronic and/or unresolved problems from previous visits are addressed in subsequent visits
- There is no evidence that the patient is placed at risk by a diagnostic or therapeutic procedure
- There is evidence that medical care is offered in accordance with Cigna-HealthSpring clinical care guidelines
 - The medical record contains appropriate notation concerning use of alcohol, cigarettes, and any substance abuse
 - There is notation regarding follow-up care, calls, or visits
 - The specific time of return is noted in days, weeks, months, or as needed
 - There is a separate medical record for each patient
 - The documentation is consistent with the assigned ICD-10 codes
 - Only authorized staff has access to medical records
 - Medical records are easily located and retrieved
 - Forms used for documentation are consistent in all records

- There is a completed immunization record in accordance with Cigna-HealthSpring child and adult preventive guidelines
 - The chart is orderly
 - Child and adult preventive screenings and services are offered/recommended
 - There is documentation of a discussion of a living will or advance directives for patients 18 years of age or older/or patients with life threatening conditions
 - Clinical findings and evaluations are documented
 - Behavioral Health providers must have communicated with a member's PCP initially and quarterly through a written summary report to advise the PCP of member's treatment and medications, if any. This will be part of the Behavioral Health provider medical record review

Providers must meet these requirements for medical record keeping. If opportunities for quality improvement are identified, Cigna-HealthSpring will present these opportunities and implement interventions.

Reporting a Quality of Care or Fraud Issue

Cigna-HealthSpring welcomes your input on potential quality of care or fraud issues. To report your concerns please contact the Member Service Department at **1-877-653-0327**.

Medicare Advantage Program Requirements

The terms and conditions herein are included to meet federal statutory and regulatory requirements of the federal Medicare Advantage program under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program"). Provider understands that the specific terms as set forth herein are subject to amendment in accordance with federal statutory and regulatory changes to the Medicare Advantage program. Such amendment shall not require the consent of provider or Cigna-HealthSpring and will be effective immediately on the effective date thereof.

1. **Books and Records; Governmental Audits and Inspections.** Provider shall permit the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to provider's performance of the Agreement and transactions related to the CMS Contract (collectively, "Records"). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit provider's Records for any particular contract period under the CMS Contract shall exist for a period of ten (10) years from the later to occur of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the "Audit Period"). Provider shall keep and

maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.

2. **Privacy and Confidentiality Safeguards.** Provider shall safeguard the privacy and confidentiality of members and shall ensure the accuracy of the health records of members. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription records) of members, including, but not limited, to the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.
3. **Member Hold Harmless.** Provider shall not, in any event (including, without limitation, non-payment by Cigna-HealthSpring or breach of the Agreement), bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from or hold responsible, in any respect, any member for any amount(s) that Cigna-HealthSpring may owe to provider for services performed by provider under the Agreement. This provision shall not prohibit provider from collecting supplemental charges, copayments or deductibles specified in the benefit plans. Provider agrees that this provision shall be construed for the benefit of the member and shall survive expiration, non-renewal or termination of the Agreement regardless of the cause for termination.
4. **Delegation of Activities or Responsibilities.** To the extent activities or responsibilities under a CMS Contract are delegated to provider pursuant to the Agreement ("Delegated Activities"), provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Cigna-HealthSpring; and (ii) in the event that the Cigna-HealthSpring or CMS determine that provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable state and/or federal laws and regulations and CMS instructions, then Cigna-HealthSpring shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Cigna-HealthSpring. To the extent that the Delegated Activities include professional credentialing services, provider agrees that the credentials of medical professionals affiliated or contracted with provider will either be (i) directly reviewed by Cigna-HealthSpring, or (ii) provider's credentialing process will be reviewed and approved by Cigna-HealthSpring and Cigna-HealthSpring shall audit provider's credentialing process on an ongoing

basis. Provider acknowledges that Cigna-HealthSpring retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals. In addition, provider understands and agrees that Cigna-HealthSpring maintains ultimate accountability under its Medicare Advantage contract with CMS. Nothing in this Agreement shall be construed to in any way limit Cigna-HealthSpring's authority or responsibility to comply with applicable regulatory requirements.

5. **Prompt Payment.** Cigna-HealthSpring agrees to pay provider in compliance with applicable state or federal law following its receipt of a "clean claim" for services provided to Cigna-HealthSpring members. For purposes of this provision, a clean claim shall mean a claim for provider services that has no defect or impropriety requiring special treatment that prevents timely payment by Cigna-HealthSpring.
6. **Compliance with Cigna-HealthSpring's Obligations, Provider Manual, Policies and Procedures.** Provider shall perform all services under the Agreement in a manner that is consistent and compliant with Cigna-HealthSpring's contract(s) with CMS (the "CMS Contract"). Additionally, provider agrees to comply with the Cigna-HealthSpring provider manual and all policies and procedures relating to the benefit plans.
7. **Subcontracting.** Cigna-HealthSpring maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of Cigna-HealthSpring. Every subcontract between provider and a subcontractor shall (i) be in writing and comply with all applicable local, state and federal laws and regulations; (ii) be consistent with the terms and conditions of this Agreement; (iii) contain Cigna-HealthSpring and member hold harmless language as set forth in Section 3 hereof; (iv) contain a provision allowing Cigna-HealthSpring and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by provider to subcontractor under such subcontract; and (v) be terminable with respect to members or benefit plans upon request of Cigna-HealthSpring.
8. **Compliance with Laws.** Provider shall comply with all state and federal laws, regulations and instructions applicable to provider's performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for provider to perform the services under the Agreement. Without limiting the above, Provider shall comply with federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of federal criminal

law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).

9. **Program Integrity.** Provider represents and warrants that provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider shall notify Cigna-HealthSpring immediately if, at any time during the term of the Agreement, provider (or any of its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider acknowledges that provider's participation in Cigna-HealthSpring shall be terminated if provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal program involving the provision of health care or prescription drug services.
10. **Continuation of Benefits.** Provider shall continue to provide services under the Agreement to members in the event of (i) Cigna-HealthSpring's insolvency, (ii) Cigna-HealthSpring's discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to Cigna-HealthSpring, and, to the extent applicable, for members who are hospitalized, until such time as the member is appropriately discharged.
11. **Incorporation of Other Legal Requirements.** Any provisions now or hereafter required to be included in the Agreement by applicable federal and/or state laws and regulations or by CMS shall be binding upon and enforceable against the parties to the Agreement and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this Manual or elsewhere in your Agreement.
12. **Conflicts.** In the event of a conflict between any specific provision of your Agreement and any specific provision of the Manual, the specific provisions of this Manual shall control.

Credentialing

The credentialing process is a vital part of the Cigna-HealthSpring Quality Improvement Program and is an essential to ensuring that the care delivered is of optimal quality. All practitioner and organizational applicants to Cigna-HealthSpring must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. Once an application has been submitted, the provider is subject to a rigorous verification

process that includes primary and secondary source verifications of all applicable information for the contracted specialty(s). Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied participation. The credentialing process may take up to sixty (60) days to complete once all application information and verifications are received. No provider can be assigned a health plan effective date or be included in a provider directory without undergoing the credentialing verification and peer review process. Once credentialing has been completed and the applicant has been approved, the provider will be notified by Network Operations of their participation effective date. Providers are advised to not see Cigna-HealthSpring members until they've received this notification. All providers who have been initially approved for participation are required to recredential at least once every three years in order to maintain their participating status.

Credentialing Application for Physicians and Non-physician Practitioners

To be credentialed by Cigna-HealthSpring, providers must submit the following information:

1. A completed Texas Standardized Credentialing Application or CAQH Credentialing application with a signed and dated attestation statement that is less than 90 days old or provide a CAQH ID number (if utilizing CAQH, must confirm that all demographic and supplemental information is current before submission). Providers who answer "yes" to any of the disclosure questions on the application must supply sufficient additional information and/or explanations for each yes response. If a provider answers "yes" to the malpractice history question, the following is required for each case:
 - Date of alleged malpractice
 - A brief description of the nature of the case and alleged malpractice
 - A statement describing the provider's role in the case
 - Current status of case, including any settlement amount
2. Copies of all current and active state medical licenses, DEA and state controlled substance certificates
3. Current and complete professional liability information on the application and a copy of provider's current malpractice insurance face sheet that includes the effective and expiration dates of the policy and term limits
4. Current and complete hospital affiliation information on the application
5. If the provider does not have hospital privileges and the specialty warrants hospital privileges, a letter detailing alternate coverage arrangements or the name of the alternate par admitting physician should be provided
6. Five years of work history (month/year format) documented on the application or a current curriculum vitae with any gaps of six (6) to twelve (12) months

explained and gaps of twelve (12) months or more explained in writing

7. Proof of Medicaid participation
8. Two (2) copies of the Cigna-HealthSpring participating provider agreement (signed and dated). Upon acceptance, an original executed copy will be returned to the provider
9. Completed and signed W-9 form

Credentialing Criteria for Physicians and Non-physician Practitioners

All Cigna-HealthSpring credentialing applications are reviewed by the designated Cigna-HealthSpring Medical Director or the Credentialing Committee on an individual basis. Cigna-HealthSpring utilizes specific selection criteria to ensure that practitioners who apply to participate meet basic credentialing and contracting standards. The credentialing criteria below represent the minimum standards. Meeting these criteria alone is not necessarily sufficient in and of itself for acceptance. Cigna-HealthSpring maintains the right to limit the provider network according to its needs.

1. Physicians must have obtained a Doctor of Medicine, Doctor of Osteopathy, Doctor of Medical Dentistry, or Doctor of Dental Surgery degree from a medical school accredited by one of the following:
 - The Liaison Committee on Medical Education (or have obtained a certificate from the Educational Council for Foreign Medical Graduates-ECFMG)
 - The American Osteopathic Association (AOA)
 - The American Board of Oral and Maxillofacial Surgery (ABOMS)
 - Non-physician providers must have graduated from an approved professional degree program for the specialty in which they are applying for participation
2. Physicians must be board certified or have completed a full residency training program accredited by one of the agencies listed below in the specialty designated as the individual's principal type of practice:
 - Accreditation council for Graduate Medical Education (ACGME)
 - American Osteopathic Association (AOA)
 - Royal College of Physicians and Surgeons or College of Family Physicians of Canada
 - American Dental Association Commission on Dental Accreditation
3. Physicians and providers must have and must maintain a current, unrestricted and unencumbered license to practice medicine granted by each State where he/she has an office listed with Cigna-HealthSpring. Any physician or provider whose license is in a probationary status and/or has terms and conditions attached to the license is not eligible for participation with Cigna-HealthSpring.

4. Providers will be credentialed in the specialty in which they have verifiable training. Cigna-HealthSpring credentialing will verify the highest level of training, which includes graduation from medical school, residency and board certification. Providers will be listed in the directory in the specialty in which they are credentialed.
5. If the physician's designated specialty includes the provision of services in a hospital setting, then:
 - The physician must demonstrate active admitting privileges at a state-licensed acute care hospital that is currently contracted with Cigna-HealthSpring or part of the evolving network.
 - If the physician does not have admitting privileges, must provide to Cigna-HealthSpring a written explanation as to why he/she does not have hospital privileges and an acceptable method of hospitalizing members. Exception: Physicians such as dermatologists do not require hospital admitting privileges.
6. If the physician does not have hospital privileges due to any reason other than a strictly voluntary relinquishment by the physician (i.e. not as a result of an investigation), the physician's application will be reviewed by a Cigna-HealthSpring Medical Director and forwarded for review to the credentialing committee.
7. PCPs must have coverage arrangements with a participating Cigna-HealthSpring provider to assure that services are available on a twenty-four-hours-a-day, seven-days-a-week basis.
8. Physicians and other providers must disclose to Cigna-HealthSpring's Credentialing Committee for review, all claims or suits alleging malpractice that have been filed against him/her or appealed or settled by the physician/provider or his or her insurance carrier in the past five (5) years.
9. Has a Medicaid/TPI/API number or can provide proof of Medicaid participation.
10. If participates in Medicare, has a Medicare number and a National Provider Identification (NPI) number.
11. Physicians and other providers who currently or have ever been excluded from Medicare and/or Medicaid participation are not eligible for participation with Cigna-HealthSpring. If a physician is accepted into Cigna-HealthSpring and then is excluded from Medicare and/or Medicaid participation, that physician will be terminated.
12. Physicians and other providers may not have opted out of Medicare. Medicaid-only providers, physical therapists, occupational therapists, and chiropractors are exempt from this requirement.
13. Physicians and other providers who prescribe medications must hold and maintain a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) certificate, if applicable, in each state where the provider provides care. For all practitioners in the State of Texas who own/operate a pain management clinic, or are employed and/or contracted with the clinic to provide services, credentialing will verify that the practitioner does not hold a DEA or CDS certificate that has been restricted by the DEA and State Public Safety agency in any jurisdiction. DEA or CDS certificates are not applicable to chiropractors. CDS certificates are not applicable for dentists; however, DEA certificates may be applicable.
14. Physicians and other practitioners must have and maintain malpractice insurance of at least \$200,000 per incident and \$600,000 aggregate. Those practitioners and physicians who will provide services only Medicare-Medicaid Plan members will have a minimum of \$100,000 per incident and \$300,000 aggregate (Exemption: Providers that are a state or federal unit of government, or a municipality, that is required to comply with and is subject to the provisions of the Texas and/or Federal Tort Claims Act).
15. Physicians and other providers must meet Cigna-HealthSpring standards for medical office access and availability of medical record documentation, as well as certain other standards.
16. If any provider is indicted for a felony or a crime, including moral turpitude, dishonesty or false statement or other acts, that provider will be suspended and may be terminated upon review by the Credentialing Committee.
17. Any physician or other provider who does not meet minimal standards for participation due to sanctions, Medicare opt-out (not applicable if a Medicaid-only or Medicare-Medicaid Plan only provider), loss of license, or encumbrance will be terminated for cause not related to quality or professional judgment. As of September 1, 2010 all pain management clinics in the State of Texas may not:
 - Operate unless the clinic is owned and operated by a medical director who is a practicing physician in Texas, has an unrestricted licensed and holds a certificate of registration from the Texas Medical Board for that clinic, and
 - May not be owned wholly or partially by a person who has been convicted, plead no contest or received deferred adjudication for an offense that constitutes a felony or misdemeanor the facts of which relate to distribution of illegal prescription drugs or a controlled substance
18. Physicians and other providers must exhibit an adequate understanding of, and agree to abide by, Cigna-HealthSpring policies relative to the provision of health care services, including ancillary services and adherence to the Cigna-HealthSpring utilization, cost containment, and quality improvement policies
19. Physicians and other providers must agree to cooperate with and/or respond to Cigna-HealthSpring investigations

of member complaints, quality activities and/or satisfaction surveys or samplings

20. Physicians and allied health professionals must agree to abide by Cigna-HealthSpring administrative protocols
21. Physicians and other providers must recognize that information from the National Practitioner Data Bank (NPDB) and confirmation of the validity of the physicians and other providers' board preparedness or certification, State License, Federal DEA Certificate and malpractice insurance information must be forthcoming and will be considered prior to credentialing

Credentialing Application for Organizational Providers

To be credentialed by Cigna-HealthSpring, organizational providers must submit the following information:

1. Completed Facility/Ancillary Credentialing application with a signed and dated attestation
2. Providers who answer "yes" to any of the questions on the application must supply additional information or an appropriate explanation with sufficient details. Negative information regarding the corporation's ability to provide services must be explained in writing by the corporation. Examples include an inability to perform essential services under the Cigna-HealthSpring participating provider agreement, loss of license, limitations or disciplinary action related to the organization and/or its medical director
3. Copies of all applicable state and federal licenses (i.e. facility license, DEA, Pharmacy license, DP certification, etc.)
4. Proof of current professional and general liability insurance as applicable
5. LTSS providers will be required to provide proof of general liability insurance of at least \$25,000/\$50,000. Services provided in the home must show evidence of coverage specific to the business. LTSS providers who also provide professional medical services must show proof of liability insurance of a minimum of \$100,000/\$300,000
6. Proof of Medicare participation if a Medicare provider
7. Proof of Medicaid participation, LTSS providers must provide evidence of current TPI/API number or other proof of Medicaid contract for each type of service applying for
8. A copy of the provider's accreditation from the appropriate, nationally-recognized accreditation body, if applicable. Note: Current accreditation is required for DME, Prosthetics/Orthotics, and non-hospital based high tech radiology providers who perform MRIs, CTs, and/or Nuclear/PET studies
9. If not accredited, a copy of the state or CMS site survey that has occurred within the last three years, including

evidence that the organization successfully remediated any deficiencies identified during the survey

10. Two (2) copies of the Cigna-HealthSpring participating provider agreement (signed and dated). Upon acceptance, an original executed copy will be returned to the provider
11. Completed and signed W-9 form

Credentialing Criteria for Organizational providers

All Cigna-HealthSpring credentialing applications are reviewed by the designated Cigna-HealthSpring Medical Director or the Credentialing Committee on an individual basis. The credentialing criteria below represent the minimum standards. Meeting these criteria alone is not necessarily sufficient in and of itself for acceptance. Cigna-HealthSpring maintains the right to limit the provider network according to its needs.

1. All Organizational providers for which licensure is required by the state in which they practice, must have and maintain a current, unrestricted and unencumbered license to practice. A provider whose license is in a probationary status and/or has terms and conditions attached to the license is not eligible for participation with Cigna-HealthSpring.
2. A copy of the provider's accreditation from the appropriate, nationally-recognized accreditation body: Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Community Health Accreditation Program (CHAP), the Continuing Care Accreditation Commission, etc. if provider is accredited.
3. If the provider is not accredited and accreditation is not available for that provider type, Cigna-HealthSpring will accept as a substitute a satisfactory CMS or State review for those providers reviewed by the State. A copy of the most recent survey performed within the past three (3) years and Corrective Action Plan shall become a part of the provider's credentialing file.

For those providers not accredited and accreditation is available for that provider type, credentialing will be denied unless there is a documented business need for that particular provider. A documented need includes, but is not limited to, an access and availability study demonstrating a need for that provider type to provide services to an underserved member population in the geographic area of that provider.

Cigna-HealthSpring will consider CMS or state reviews as the on-site review for all non-accredited Facilities and will conduct its own on-site review only in response to quality of care concerns or as warranted subject to receipt of a complaint.

1. As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies

and inpatient, residential or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a state or CMS site survey completed within the past three (3) years. Providers must score a minimum of 85% on the site survey tool. Providers who fall below acceptable limits will be required to submit a written Corrective Action Plan (CAP) within thirty (30) days and may be re-audited at minimum within sixty (60) days to verify specific corrective action items as needed. Providers who fail to provide an appropriate CAP or who are unable to meet minimum standards even after re-auditing will not be eligible for participation.

2. All Organizational providers must have and maintain professional and general liability insurance as applicable. LTSS providers will be required to provide proof of general liability insurance of at least \$25,000/\$50,000. Services provided in the home must show evidence of coverage specific to the business. LTSS providers who also provide professional medical services must show proof of liability insurance at a minimum of \$100,000/\$300,000. Providers that are a state or federal unit of government, or a municipality, that is required to comply with and is subject to the provisions of the Texas and/or Federal Tort Claims Act) are exempt from these requirements.
3. Any criminal indictment of the corporation must be addressed in the application.
4. Providers who are or have been excluded from Medicare and/or Medicaid participation or have been excluded, suspended, and/or disqualified from participating in any other government health related program are not eligible for participation with Cigna-HealthSpring. If a provider is accepted into Cigna-HealthSpring and then is excluded from Medicare, Medicaid, or any other government health related program, the physician will be terminated from Cigna-HealthSpring.
5. Must participate in the Medicaid program.
6. Organizational providers must agree to cooperate with and/or respond to Cigna-HealthSpring investigations of member complaints, quality activities and/or satisfaction surveys or samplings.
7. Organizational providers must agree to abide by Cigna-HealthSpring's administrative protocols.
8. An organizational provider who does not meet minimal standards for participation due to sanctions, loss of license, or encumbrance will be terminated from Cigna-HealthSpring's provider network for cause not related to quality or professional judgment.

Credentialing Committee/Peer Review Process

All initial applicants and re-credentialed providers are subject to a peer review process prior to approval or re-approval as a participating provider. Providers who meet all of the acceptance criteria may be approved by the Medical

Director. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of contracted primary care, specialty providers and LTSS representatives, and has the authority to approve, deny or terminate an appointment status to a provider. All information considered in the credentialing and re-credentialing process must be obtained and verified within one hundred eighty (180) days prior to presentation to the Medical Director or the Credentialing Committee. All providers must be credentialed and approved before being assigned a participating effective date.

Ongoing Participation Requirements for all Cigna-HealthSpring Providers

Once a provider is accepted for participation with Cigna-HealthSpring, he/she must continually maintain and comply with all Cigna-HealthSpring policies and procedures. This includes the following requirements:

1. Under their Cigna-HealthSpring Participating provider agreements, providers must notify Cigna-HealthSpring in writing within five (5) days of any changes in status relative to the established credentialing criteria or any other matter that could potentially affect a continued contractual relationship with Cigna-HealthSpring such as:
 - Significant or prolonged illness;
 - Leave of absence;
 - Suspension or modification of privileges;
 - A change in physical or behavioral health status that affects the provider's ability to practice;
 - Loss of accreditation status from any nationally recognized accreditation body
 - Any other action that materially changes the provider's ability to provide service to members.
2. Providers who maintain more than one office location must include all offices locations in the Cigna-HealthSpring provider network.
3. Compliance with the after-hours coverage requirement defined in the "provider Responsibilities" section of this provider manual.
4. If the provider's Cigna-HealthSpring Participating provider agreement is terminated involuntarily, a one-year period must elapse before the provider can reapply. Upon reapplication, all circumstances of the termination/resignation must be revealed and will be considered. If either party terminates the Cigna-HealthSpring Participating provider agreement or there is a break in service of more than thirty (30) calendar days, the practitioner shall be initially credentialed before rejoining the network.
5. Providers must inform both the MCO and HHSC's administrative services contractor of any changes to

the provider's address, telephone number, group affiliation, etc.

Re-Credentialing

It is imperative that providers complete the re-credentialing process in order to remain in good standing and continue to treat Cigna-HealthSpring members. Providers must be formally re-credentialed every thirty-six (36) months.

Three (3) separate attempts will be made to obtain the required information via mail, fax, email, or telephonic request during the data collection period. Non-compliance with the re-credentialing process in advance of the provider's due date for re-credentialing will result in termination from the Cigna-HealthSpring provider network. The only exception shall be for providers who are on active military assignment, maternity leave, or sabbatical. In these cases, the provider shall be re-credentialed upon his or her return. The reason will be documented in the provider's file and in applicable databases.

Provider Rights - Credentialing and Re-Credentialing

Providers' rights related to the Cigna-HealthSpring credentialing and re-credentialing process include:

1. The provider has the right to review information obtained from any outside source to evaluate their credentialing application and submitted to Cigna-HealthSpring in support of his or her credentialing/re-credentialing application except for peer review information that is confidential, protected, and restricted under State and federal peer review laws. The provider may submit a written request to review his/her file information at least thirty (30) days in advance at which time the Plan will establish a time for the provider to view the information at the Plan's offices
2. The provider has the right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the provider. He/she will be given the opportunity to clarify and/or correct the information prior to the finalization of the credentialing/re-credentialing process. In instances where there is a substantial discrepancy in the information, Credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within thirty (30) days of notification
3. The provider has the right, upon request, to be informed of the status of his/her credentialing or re-credentialing application. A provider may request the status of their application either telephonically or in writing. The Plan will respond within two (2) business days and may

provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated review date, and approval status

4. Credentialing and re-credentialing processes are conducted in a nondiscriminatory manner. Through the universal application of specific assessment criteria, Cigna-HealthSpring ensures fair and impartial decision-making in the credentialing process and does not make decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients in which the provider specializes. All decisions are based on the aforementioned criteria
5. Upon written request from an applicant or a provider who is already credentialed, Cigna-HealthSpring shall disclose the relevant credentialing criteria outlined above
6. Appeal rights apply to participating Cigna-HealthSpring providers who have been terminated from the provider network and new providers who have been denied initial credentialing if the denial decision is based on adverse information or not meeting credentialing requirements. Cigna-HealthSpring does not offer appeal rights to any initial applicant who was denied due to quality of care issues or failure to meet Medicare and/or Medicaid participation requirements
7. Cigna-HealthSpring will not exclude from credentialing or terminate a health care provider based solely on having a practice that includes a substantial number of patients with expensive medical conditions
8. In the event that a provider's participation is denied, limited, suspended or terminated by the Credentialing Committee, the provider is notified in writing within sixty (60) days of the decision. Notification will include a) the reasons for the action, b) outlines the appeals process or options available to the provider, and c) provide the time limits for submitting an appeal. All appeals will be reviewed by a panel of peers. When termination or suspension is the result of quality deficiencies, the appropriate state and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action

Cigna-HealthSpring will provide information regarding further provider rights in the event that a provider is denied credentialing.

Non-discrimination in the Decision-making Process

Cigna-HealthSpring's credentialing program is compliant with all guidelines from the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and state regulations as applicable. Through the universal application of specific assessment criteria, Cigna-HealthSpring ensures fair and impartial decision-making in the credentialing process, and does not make credentialing decisions based on an applicant's race, gender, age, ethnic

origin, sexual orientation, or due to the type of patients or procedures in which the provider specializes.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of their plan effective date. Providers are advised to not see Cigna-HealthSpring members until they receive notification of their plan participation and effective date. Applicants who are denied by the Credentialing Committee will be notified via a certified letter within sixty (60) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process and Notification of Authorities

In the event that a provider's participation is limited, suspended, or terminated, the provider is notified in writing within sixty (60) days of the decision. Notification will include a) the reasons for the action, b) outline of the appeals process or options available to the provider, and c) the time limits for submitting an appeal. All appeals will be reviewed by a panel of peers. When termination or suspension is the result of quality deficiencies, the appropriate state and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and re-credentialing process is considered confidential and is handled and stored in a confidential and secure manner as required by law and regulatory agencies. Confidential practitioner credentialing and re-credentialing information will not be disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing Monitoring

Cigna-HealthSpring conducts routine, ongoing monitoring of license sanctions, Medicare/Medicaid sanctions and the CMS Opt Out list between credentialing cycles. Participating providers who are identified as having been sanctioned, are the subject of a complaint review, or are under investigation for or have been convicted of fraud, waste or abuse, are subject to review by the Medical Director and/or the Credentialing Committee who may elect to limit, restrict or terminate participation. Any provider who's license has been revoked or suspended or has been excluded, suspended and/or disqualified from participating in any Medicare, Medicaid or any other government health related program or who has opted out of Medicare will be automatically terminated from the plan.

Provider Directory

To be included in Provider Directories or any other member information, providers must be fully credentialed and approved. Directory specialty designations must be commensurate with

the education, training, board certification and specialty(s) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by credentialing.

Special Access Requirements

Cigna-HealthSpring provides services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities. Cigna-HealthSpring serves these members in a manner that recognizes values, affirms and respects their worth and protects and preserves the dignity of each. As such, Cigna-HealthSpring has implemented several key initiatives that are specifically designed to meet the special access needs of the Medicare-Medicaid Plan population. These initiatives include a comprehensive cultural competency program, interpreter and translation services, and customized member materials that take into consideration variances in the population's reading levels.

Cultural Sensitivity

Cigna-HealthSpring ensures that all member communication is sensitive to the vast cultural differences spanning the Medicare-Medicaid Plan population. Cigna-HealthSpring makes it a priority to employ and develop associates who can communicate effectively with members of various ages and cultural backgrounds. Cigna-HealthSpring supports the belief that providing quality health care means treating the whole patient and not just the medical condition. Cultural sensitivity plays a key role in accomplishing this goal successfully. As such, Cigna-HealthSpring encourages and advocates for providers to provide culturally competent care for its members. Following is a list of cultural competency principles for health care providers to consider in the health care delivery process:

Knowledge

Knowledge and understanding of differences are essential components of cultural competency. To be culturally competent a provider must have an understanding of:

- Race, ethnicity and influence
- The historical factors which impact the health of minority populations, such as racism and immigration patterns
- The particular psycho-social stressors relevant to minority patients including war trauma, migration, acculturation stress, and socioeconomic status
- The cultural differences within minority groups
- The minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network
- The differences between "culturally acceptable" behavior of psychopathological characteristics of different minority groups

- > Indigenous healing practices and the role of religion in the treatment of minority patients
- > The cultural beliefs of health and help-seeking patterns of minority patients
- > The health service resources for minority patients
- > Public health policies and their impact on minority patients and communities

Skills

To treat culturally-diverse populations successfully, health care providers must develop ability to

- > Interview and assess minority patients based on a psychological/social/biological/cultural/political/spiritual model
- > Communicate effectively with the use of cross cultural interpreters
- > Diagnose minority patients with an understanding of cultural differences in pathology
- > Avoid under-diagnosis or over-diagnosis
- > Formulate treatment plans that are culturally sensitive to the member's and family's concept of health and illness
- > Utilize community resources such as church, community-based organizations (CBOs), and self-help groups
- > Provide therapeutic and pharmacological interventions, with an understanding of the cultural differences in treatment expectations and biological response to medication
- > Request for consultation

Attitudes

Aside from having the knowledge and skill set to treat culturally-diverse populations, health care providers must adopt positive attitudes and foster respect for their patients. This includes respecting and appreciating the:

- > "Survival merits" of immigrants and refugees
- > Importance of cultural forces
- > Holistic view of health and illness
- > Importance of spiritual beliefs
- > Skills and contributions of other professional and paraprofessional disciplines
- > Transference and counter transference issues

Interpreter/Translation Services

Cigna-HealthSpring ensures its staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. Cigna-HealthSpring arranges for language interpretation services for over 170 languages through the TeleLanguage. TeleLanguage

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

Trained interpreters must be used when technical, medical, or treatment information is discussed. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality or confidentiality is critical unless specifically requested by the member.

Reading/Grade Level Consideration

All Cigna-HealthSpring member materials and website content are specially designed to take into consideration the Medicare-Medicaid Plan population's needs. Materials are intended to be user-friendly and concise and they are written at a reading level that is at or below 6th grade as measured by the Flesch Reading Ease Test.

All member materials regarding advance directives are written at a 6th grade reading comprehension level, except where a provision is required by State or federal law and the provision cannot be reduced or modified to a 6th grade reading level because it is a reference to the law or is required to be included "as written" in the State or federal law.

Direct Access to a Specialty Care Provider for Members with Special Health Care Needs

Specialty Care Providers can act as PCPs under specific circumstances. A Specialty Care Provider may be designated by Cigna-HealthSpring as a PCP for Members who require a specialized physician to manage their specific health care needs such as those living with HIV or AIDS. Children and Adults with Special Health Care Needs also may designate a Specialty Care Provider as a PCP to coordinate their care. A Specialty Care provider acting in the PCP role must agree to adhere to Cigna-HealthSpring's PCP standards. To request to be a PCP, Specialty Care Providers should call the Cigna-HealthSpring Provider Services Department at **1-877-653-0331**.

Member Rights and Responsibilities

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

Cigna-HealthSpring members receive a complete list of the following member Rights and Responsibilities in their member Handbook. The member Handbook is included in the Welcome Kit.

Members' Rights:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
 - Be treated fairly and with respect; and
 - Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - Be told how to choose and change your health plan and your Primary Care Provider;
 - Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan;
 - Change your Primary Care Provider;
 - Change your health plan without penalty;
 - Be told how to change your health plan or your Primary Care Provider
3. You have the right to ask questions and get answers about anything you don't understand. That includes the right to:
 - Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated; and
 - Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - Work as part of a team with your provider in deciding what health care is best for you; and
 - Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
 - Make a complaint to your health plan or to the State Medicaid program about your health care, your provider or your health plan;
 - Get a timely answer to your complaint;
 - Use the plan's appeal process and be told how to use it; and

- Ask for a fair hearing from the State Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need;
 - Get medical care in a timely manner;
 - Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act;
 - Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information; and
 - Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
 7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you don't want to do, or is to punish you.
 8. You have a right to know that doctors, hospitals, and others who care for you can advise you about their health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
 9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities

You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:

- Learn and understand your rights under the Medicaid program;
- Ask questions if you don't understand your rights; and
- Learn what choices of health plans are available in your area.

You must abide by the health plan and Medicaid policies and procedures. That includes the responsibility to:

- Learn and follow your health plan rules and Medicaid rules;
- Choose your health plan and a Primary Care Provider quickly;

- > Make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan;
- > Keep your scheduled appointments;
- > Cancel appointments in advance when you can't keep them;
- > Always contact your Primary Care Provider first or your non-emergency medical needs;
- > Be sure you have approval from your Primary Care Provider before going to a Specialty Care Provider; and
- > Understand when you should and shouldn't go to the emergency room.

You must share information about your health with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:

- > Tell your Primary Care Provider about your health;
- > Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated; and
- > Help your providers get your medical records.

You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:

- > Work as a team with your provider in deciding what health care is best for you;
- > Understand how the things you do can affect your health;
- > Do the best you can to stay healthy;
- > Treat providers and staff with respect; and
- > Talk to your provider about all of your medications.

Member's Right to Designate an OB/GYN

Attention female members

Cigna-HealthSpring members have the right to pick an OB/GYN without a referral from their PCP but this doctor must be in the same network as the member's Primary Care Provider. An OB/GYN can provide the following services:

- > One well-woman checkup each year
- > Care related to pregnancy
- > Care for any female medical condition
- > Referral to Specialty Care Provider within the network

Member Complaint and Appeal Process

Cigna-HealthSpring's member Complaint and Appeal process is designed to facilitate prompt resolution to member issues and promote member satisfaction. Cigna-HealthSpring's member Handbook contains a written description of Cigna-HealthSpring's Complaint process in a format that is easy to understand. Additionally, Cigna-HealthSpring has member advocates who are available to help members file complaints, if necessary. The member has a right to file a complaint or an appeal to Cigna-HealthSpring or HHSC.

A **Complaint** means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. As provided by 42 C.F.R. 438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid member's rights.

An **Action** means:

- > The denial or limited authorization of a requested Medicaid service, including the type or level of service
- > The reduction, suspension, or termination of a previously authorized service
- > The denial in whole or in part of payment for service
- > The failure to provide services in a timely manner
- > The failure of an MCO to act within the timeframes set forth in the Contract and 42 C.F.R 438.408(b)
- > For a resident of a rural area with one MCO, the denial of a Medicaid member's request to obtain services outside of the Network
- > An Adverse Determination is one type of Action.

An **Appeal** is a formal process by which a member or his or her representative requests a review of the MCO's Action, as defined above.

An **Authorized Representative** is any person or entity acting on behalf of the member, for whom Cigna-HealthSpring has received the member's written consent. A provider may be an authorized representative.

Expedited Appeal means an appeal to the MCO in which the decision is required quickly based on the member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Member Complaint Process

Member Complaints can be filed verbally or in writing by contacting Cigna-HealthSpring as follows:

- > Cigna-HealthSpring Appeals & Complaint Department
- By mail:
P.O. Box 211088
Bedford, TX 76095
- By fax: **1-877-809-0783**

- > Cigna-HealthSpring Member Service Department
- By phone: **1-877-653-0327**
Monday to Friday, 8 a.m. to 8 p.m. Central Time

A Cigna-HealthSpring member Advocate is available to help file a Complaint if necessary.

If a Complaint is received verbally by telephone, Cigna-HealthSpring's Provider Services representatives collect detailed information about the Complaint and route the Complaint electronically to the Appeals and Complaints Department for handling. Within five (5) business days of receipt of a Complaint, Cigna-HealthSpring sends the member or the member's authorized representative a letter acknowledging receipt of the Complaint. The acknowledgement letter will include the date the Complaint was received, a description of the Complaint process, and the timeline for resolution. Cigna-HealthSpring will investigate the Complaint and take corrective action if necessary. Cigna-HealthSpring will issue a response letter to the member or the member's authorized representative within thirty (30) calendar days from the date the Complaint was received. The response letter will include a description of the resolution and the process to appeal the Complaint if the member or the member's authorized representative is not satisfied with Cigna-HealthSpring's decision.

Cigna-HealthSpring will ensure that every Complaint, whether received by telephone or in writing, will be recorded with the following details:

- > Date
- > Identification of the individual filing the Complaint
- > Identification of the individual recording the Complaint
- > Nature of the Complaint
- > Disposition of the Complaint (i.e., how the Complaint was resolved)
- > Corrective action required
- > Date resolved

If members are not satisfied with Cigna-HealthSpring's resolution to a Complaint, they can file a Complaint with the HHSC by calling **1-888-566-8989** or by writing to:

Texas Health and Human Services Commission
Health Plan Operations - H-320
ATTN: Resolution Services
P.O. Box 85200
Austin, TX 78708-5200

If the member has Internet access, he/she can email to:
HPM_Complaints@hhsc.state.tx.us

Members must exhaust the MCO's Complaint Process prior to contacting HHSC.

Member Appeal Process

If a covered service is denied, delayed, limited, or stopped, Cigna-HealthSpring will notify the member in writing and provide an Appeal Form with instructions on how to file an Appeal. Members have the option to request an Appeal for denial of payment of services in whole or in part. Members may request an Appeal verbally or in writing by contacting Cigna-HealthSpring as follows:

- > Cigna-HealthSpring Appeals & Complaint Department
- By mail:
P.O. Box 211088
Bedford, TX 76095
- By fax: **1-877-809-0783**
 - > Cigna-HealthSpring Member Service Department
- By phone: **1-877-653-0327**
Monday to Friday, 8 a.m. to 8 p.m. Central Time

A Cigna-HealthSpring member Advocate is available to help file an Appeal if necessary.

If an Appeal is received verbally by telephone, Cigna-HealthSpring will send the member or member's authorized representative an Appeal Form to document the appeal, unless an Expedited Appeal is requested. Instructions for where to return the completed Appeal Form will be included with the Appeal Form. If Cigna-HealthSpring does not receive the signed Appeal Form within thirty (30) days from the date the Appeal request was received, the Appeal will not be reviewed and the case will be closed. Within five (5) days of receipt of a signed Appeal Form or a written appeal, Cigna-HealthSpring will send written acknowledgement to the member or the member's authorized representative. The acknowledgement letter will include the date the appeal was received, a description of the appeal process, and the timeline for resolution.

In order to ensure continuity of currently authorized services, the member may request continuation of services while an Appeal is being reviewed. To do so, the member must file the Appeal on or before the later of ten (10) days following the mailing of the Action or the intended effective date of the proposed action. The member may be required to pay the cost of the services furnished while the Appeal is pending, if the final decision is adverse to the member. If Cigna-HealthSpring receives an oral request for an Appeal, it must be confirmed by an Appeal Form signed by the member or the member's authorized representative, unless an Expedited Appeal is requested.

Cigna-HealthSpring mails an acknowledgement letter to a member or the member's authorized representative

within five (5) business days of receipt of the written Appeal, acknowledging the date of receipt and indicating the document(s) that the Appealing party must submit for review and date by which the document(s) is due.

Within thirty (30) calendar days of receipt of the Appeal, Cigna-HealthSpring responds in writing to the member or the member's authorized representative and to the member's provider. The member or Cigna-HealthSpring may request that the timeframe for resolving an Appeal be extended by up to fourteen (14) calendar days if there is a need for more information that will influence the determination on the Appeal. If an extension is requested, Cigna-HealthSpring sends a letter to the member or the member's authorized representative and to the member's provider, explaining the reason for the delay.

If the Appeal is denied, the Appeal determination letter includes a clear statement of the clinical basis for the denial, the specialty of the physician or other health care provider making the denial and the Appealing party's right to seek review of the denial through the Fair Hearing process.

Member Expedited Appeal

Cigna-HealthSpring maintains an expedited Appeal process in the event that the member or the member's authorized representative states orally or in writing in the Appeal that the member's health or life is in serious jeopardy as a result of the Adverse Determination. A member Advocate is available to help file an Expedited Appeal, if necessary. If Cigna-HealthSpring accepts the request for an expedited resolution, the request is investigated and a resolution is provided to the member or the member's authorized representative within three (3) business days, except if the Expedited Appeal is related to an ongoing emergency or denial of continued hospitalization. In these cases, the Expedited Appeal must occur in accordance with the medical or dental immediacy of the case, but not later than one (1) business day after receiving the member's request for Expedited Appeal.

A Cigna-HealthSpring member Advocate is available to help file an Appeal if necessary.

If Cigna-HealthSpring determines the member's health or life is not in serious jeopardy and denies the request for an expedited reconsideration, the member or the member's authorized representative is immediately informed orally and a written notice follows within two (2) calendar days. The Appeal becomes subject to standard Appeal timeframes.

Written notification of the outcome of the Expedited Appeal is issued as soon as possible, but no later than three (3) calendar days after the date Cigna-HealthSpring receives the Appeal. If the member or the member's authorized representative is not satisfied with Cigna-HealthSpring's decision, he/she may file an Appeal with the State. Members have the right to Appeal directly to the State any time during or after Cigna-HealthSpring's Appeal process. If the member does not agree with decision, he/she may request a Fair Hearing

from the State. The member or the member's authorized representative must first exhaust Cigna-HealthSpring's internal Expedited Appeal process prior to requesting an Expedited Fair Hearing

Member Request for State Fair Hearing

If a member, as a member of Cigna-HealthSpring, disagrees with the health plan's decision, the member has the right to ask for a fair hearing. If a covered service is denied, delayed, limited, or stopped, Cigna-HealthSpring will notify the member in writing. The member may name someone to represent him or her by writing a letter to Cigna-HealthSpring telling the MCO the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the fair hearing within 90 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the fair hearing within 90 days, the member may lose his/her right to a fair hearing. To ask for a fair hearing, the member or the member's representative should either send a letter to the health plan at:

- Cigna-HealthSpring Appeals & Complaint Department
- By mail:
P.O. Box 211088
Bedford, TX 76095
- By fax: **1-877-809-0783**
 - Cigna-HealthSpring Member Service Department
- By phone: **1-877-653-0327**
Monday to Friday, 8 a.m. to 8 p.m. Central Time

If the member asks for a fair hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, and at least until the final hearing decision is made. If the member does not request a fair hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped.

If the member asks for a fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most fair hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member or the member's authorized representative asked for the hearing.

At any time during the Appeal process or after Cigna-HealthSpring upholds an Action of an Appeal, the member or the member's authorized representative may seek review of that Appeal determination through the Fair Hearing process.

Hospital Discharge Appeals

The member must receive a written notice of explanation called an Important Message from Medicare about your Rights. The member has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice will include information on filing the QIO appeals. The member must contact the QIO before he/she leaves the hospital but no later than the planned discharge date.

APPENDICES




89

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Appendix A, Cigna-HealthSpring Member Identification Card

Medicare & Medicaid Dual Eligible Member

1
2
3
4

Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan)

Name: <Member Name>

Member ID: <Member ID>

Health Plan (80840)

Medicaid ID: <Member Medicaid ID>

PCP: <Provider Name>


PCP Effective Date: <PCP Effective Date>

PCP Phone: <Provider Phone #>

RxBIN: <017010>

RxPCN: <CIHSCARE>

H8423-001



Website/Sitio web: www.careplantx.com

<barcode>

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. En caso de emergencia, llame al 911 o vaya a la sala de emergencia mas cercana. Después de recibir cuidado, llame a su PCP dentro de 24 horas o lo antes posible.

Member Services/Servicios al miembro: <1-877-653-0327>

Behavioral Health/Salud del comportamiento: <1-877-725-2539>

Service Coordination/Coordinador de servicios: <1-877-725-2688>

Hearing Impaired/Personas con problemas de la audición: <711>

For Prior Authorization/De autorizacion previa: <1-877-562-4402>

Pharmacy Help Desk: <1-844-265-1770>

Send pharmacy claims to: <P.O. Box 20002, Nashville, TN 37202>

Send Medical claims to: <P.O. Box 981709, El Paso, TX 79998-1709>

Claims inquiry: <1-877-653-0331>

5
6
7
8
9
10
11

How to read Cigna-HealthSpring ID Card: Medicare and Medicaid Dual Eligible

Front

1. The Cigna-HealthSpring and Medicare-Medicaid Plan Logos
2. Member's Name
3. Member's ID #, issued by Cigna-HealthSpring
4. Member's Medicaid Member ID#, issued by HHSC

Back

5. The Member Service phone number, available Monday to Friday, 8 a.m. to 8 p.m. Central Time
6. The Behavioral Health Crisis Hotline number.
7. The Service Coordination Department phone number
8. The TTY number for Hearing Impaired Members. For additional Hearing Impaired services, please contact TTY/Texas Relay at **1-800-735-2989** (English) or **1-800-662-4954** (Spanish).
9. Provider's Prior Authorization phone number
10. The address where providers send claims
11. Claims inquiry phone number

Appendix C, Sample Form 1027-A Temporary Medicaid Identification



Texas Department of Human Services

Form 1027-A/1-2000

| | | |
|--|--------------------|----------------------|
| | Name of the Doctor | Name of the Pharmacy |
|--|--------------------|----------------------|

MEDICAID ELIGIBILITY VERIFICATION

THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES

Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid identification form is lost or late. The client number must appear on all claims for health services.

| | |
|---------------------------|-------------------------------------|
| Date Eligibility Verified | Verification Method TIERS |
|---------------------------|-------------------------------------|

| CLIENT NAME | DATE OF BIRTH | CLIENT NO. | ELIGIBILITY DATES | | MEDICARE CLAIM NO. | STAR/STAR-PLUS HEALTH PLAN INFORMATION Plan Name and Member Services Toll-Free Telephone No. |
|-------------|---------------|------------|-------------------|---------|--------------------|---|
| | | | FROM | THROUGH | | |
| | | | | | | |

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form 3087) for the current month. I have requested and received Form 1027-A, Medical Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

CAUTION: If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Signature-Client or Representative

Date

Office Address and Telephone No.

| | | | |
|-------------------------|--------------------|-----------------------|------|
| Name of the Worker | Worker Number | Worker Signature | Date |
| Name of the Supervisor* | Supervisor Number* | Supervisor Signature* | Date |

* or Authorized Lead Worker

Appendix D, Authorization Requirements



Authorization Requirements Medicare/Medicaid Plan Only

Phone: 877-725-2688 Fax: Inpatient 877-809-0786 /Outpatient 877-809-0787

All Hospitalizations require authorization including Transplants.

Pre-scheduled, elective admissions must have prior authorization prior to admission.

Emergent inpatient admissions require notification by the close of the next business day following the admission.

All Non-Participating/Out-of-Network Providers require prior authorization for all outpatient and elective inpatient services.

Prior Authorization is required for the services listed below whether billed on UB-04 or CMS 1500.

| | |
|---|---|
| <p>Labs Place of Service 11, 22, or 81 Exception: LABS- The following routine lab services may be performed in a participating provider's office without authorization: 81001* 81002 *81003* 81005 *81007 *81025*82010* 82270 *82272 *82570* 82947 *82962 83026 *83036 *84478* 84520* 84703 *85013 *85014* 85018 *85610 *87449 *87804* 87880.</p> <p>All other lab specimens should be drawn in the provider's office and sent to a participating lab provider such as Quest, CPL, LapCorp or ProPath... The provider will be reimbursed for the lab draw.</p> <p>All other lab services completed anywhere else <i>must be authorized prior to services being rendered.</i></p> | <p>Skilled Nursing Facility Place of Service 31</p> <ul style="list-style-type: none"> All SNF admission <p>Inpatient Acute Care Place of Service 21</p> <ul style="list-style-type: none"> All medical/surgical All Behavioral Health All Inpatient Rehabilitation All Long Term Acute Care (LTAC) <p>Custodial Nursing Facility Place of Service 32</p> <ul style="list-style-type: none"> Add-On services |
| <p>Health Care Office Place of Service 11, 50, 71, 72</p> <ul style="list-style-type: none"> Ambulatory Blood Pressure Monitoring Chiropractor-for all services except manipulations, up to 6 visits Hearing Aids (requires 30-day trial) Pain Management procedures | <p>DME</p> <ul style="list-style-type: none"> All Miscellaneous Codes Any supplies/equipment requests that exceed Medicaid allowable benefit All equipment rentals |

Appendix D, Authorization Requirements

| | |
|---|---|
| <p>Health Care Office Place of Service 11, 50, 71, 72 (continued)</p> <ul style="list-style-type: none"> • Radiology: CT, MRI, MRA, PET • Sleep studies • Viscosupplementation: J7321, J7323, J7324, J7325, J7326 • Treatment with injection J1300 Eculizumab, 10 mg • Treatment with injection J9354 Ado-Trastuzumab Emtansine <p>Home Health Place of Service 12</p> <ul style="list-style-type: none"> • ECI notification only • Enteral feedings • Nutritional Supplements • Home Health Aide • Occupational therapy excluding initial evaluation • Physical therapy excluding initial evaluation • Skilled nursing excluding initial evaluation • Speech therapy after evaluation. (Speech therapy is covered for members 20 and younger in the home setting. Speech therapy is not covered for adults in home setting.) <p>Hospice Place of Service 34</p> <ul style="list-style-type: none"> • Hospice care-notification only <p>Transportation Place of Service 41/42</p> <ul style="list-style-type: none"> • Ambulance-non -emergent air or ground <p>LTSS and STAR+PLUS Waiver Services</p> <ul style="list-style-type: none"> • Personal Attendant Services (PAS) • Protective Supervision • Day Activity & Health Services (DAHS) • Adult Foster Care (AFC) • Assisted Living (AL) • Emergency Response Services (ERS) • Home Delivered Meals (HDM) | <p>DME (continued)</p> <ul style="list-style-type: none"> • All purchases over \$500 (per claim line) <p>Prosthetics/Orthotics</p> <ul style="list-style-type: none"> • All require authorization <p>Outpatient Procedures Place of Service 22</p> <ul style="list-style-type: none"> • All Miscellaneous Codes • Abortion • Cardiac Rehabilitation • Circumcision 1yr and older • Cosmetic Surgeries are not covered • Dental Anesthesia • ECI Notification • Enhanced External Counterpulsation (EECP) • EEG with video monitoring • Health/Behavior Assess/Intervention HBAI(see below) • Hernia repairs-ALL types • Hyperbaric Oxygen Therapy • Hysterectomies-ALL types • Implantable Devices ALL types such as Cochlear Implants, pacemaker, pain pumps, defibrillators, insulin pump • Occupational therapy excluding initial evaluation • Oral Surgery • Pain Management Procedures • Physical Therapy excluding initial evaluation • Plastic and Reconstructive Surgery • Radiology: CT, MRI, MRA, PET • Sleep Studies |
|---|---|

Appendix D, Authorization Requirements

| | |
|---|---|
| <p>LTSS and STAR+PLUS Waiver Services (continued)</p> <ul style="list-style-type: none"> • Minor Home Modifications (MHM) • Nursing Services and Therapy Services (LTSS) • Transition Assistance Services (TAS) • Cognitive Rehabilitation Therapy (CRT) • Supportive Employment • Employment Assistance • Community First Choice • Prescribed Pediatric Extended Care Center (PPECC) • Nutritional Supplements | <p>Outpatient Procedures Place of Service 22 (continued)</p> <ul style="list-style-type: none"> • Speech therapy excluding initial evaluation • Sterilization –Prior auth and Physician Statement required with claim • Telemonitoring • TMJ Procedures • Transplant Evaluations • Varicose Vein Procedures • Vagus Nerve Stimulation • Wound Care |
| <p>Behavioral Health</p> <ul style="list-style-type: none"> • All Inpatient Admissions • Partial Hospital Program • Outpatient Psychological and Neuropsychological Testing • Outpatient Electroconvulsive Therapy (ECT) <p>Substance Use Disorder Services</p> <ul style="list-style-type: none"> • Ambulatory Detoxification • Residential Detoxification • Residential Treatment • Medication Assisted Therapy (MAT)-Notification Only • Intensive Outpatient Program (IOP) <p>Health and Behavior Assessment and Intervention Services (HBAI)</p> | <p>Mental Health Rehabilitation Services</p> <ul style="list-style-type: none"> • Adult Day Program for Acute Needs • Medication Training and Support • Skills Training and Development • Psychosocial Rehabilitative Services <p>Targeted Case Management</p> <ul style="list-style-type: none"> • Routine Mental Health Case Management -Adult • Routine Case Management-Child or Adolescent • Intensive Case Management-Child or Adolescent |

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Appendix E, Prior Authorization Request Form

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

| | | | |
|--------------|--------|------|-------|
| Issuer Name: | Phone: | Fax: | Date: |
|--------------|--------|------|-------|

SECTION II — GENERAL INFORMATION

| | |
|---|------------------------------|
| Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent | Clinical Reason for Urgency: |
| Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment | Prev. Auth. #: |

SECTION III — PATIENT INFORMATION

| | | | |
|---------------------------------|--------------------------|----------|--|
| Name: | Phone: | DOB: | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown |
| Subscriber Name (if different): | Member or Medicaid ID #: | Group #: | |

SECTION IV — PROVIDER INFORMATION

| Requesting Provider or Facility | | Service Provider or Facility | |
|---|------------|--|------------|
| Name: | | Name: | |
| NPI #: | Specialty: | NPI #: | Specialty: |
| Phone: | Fax: | Phone: | Fax: |
| Contact Name: | Phone: | Primary Care Provider Name <i>(see instructions)</i> : | |
| Requesting Provider's Signature and Date <i>(if required)</i> : | | Phone: | Fax: |

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

| Planned Service or Procedure | Code | Start Date | End Date | Diagnosis Description (ICD version__) | Code |
|------------------------------|------|------------|----------|---------------------------------------|------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| |
|--|
| <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____ |
| <input type="checkbox"/> Home Health (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____ |
| <input type="checkbox"/> DME (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) <i>(Medicaid only: Title 19 Certification Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No)</i> Equipment/Supplies (include any HCPCS codes): _____ Duration: _____ |

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

Appendix G, Outpatient Authorization Form

MEDICAID Prior Authorization Request Form – OUTPATIENT

Please fax to: 1-877-809-0790 (Home Health Services) or 1-877-809-0787 (All Other Requests)
 (Phone: 1-877-725-2688)



*** Required Field – please complete all required fields to avoid delay in processing**

Note: In an effort to process your request in a timely manner, please submit any pertinent clinical information (i.e. progress notes, treatment rendered, test/lab results or radiology reports) to support the request for services. Any request for a non-contracted provider must include documentation to substantiate the reason for the request. **(When all required information has been submitted we will complete your request within 3 business days.)**

| | | |
|--|--|--|
| <input type="checkbox"/> Expedited Requests – defined as <i>danger to a member's health if not provided within 24 hours.</i> (Phone: 1-877-725-2688 Then press prompt 3, for expedited prior authorization. | | |
| ▶ Member Information: | | |
| *Member Name: _____ | | |
| *Member DOB: / / | * Member ID: _____ | *Date of Service: / / |
| ▶ Requesting Provider Information: | | |
| *PCP/Requesting Provider: _____ | Contact Person: _____ | |
| | *Phone #: _____ | |
| | *Fax #: _____ | |
| ▶ Referring to (servicing) provider information: if below fields are not answered, Cigna-HealthSpring® will automatically assign Cigna-HealthSpring's participating provider network to the member: | | |
| *Servicing Provider: <input type="checkbox"/> Non-contracted Tax ID #: _____ | NPI#: _____ | Contact Person: _____ |
| | | *Phone #: _____ |
| | | *Fax #: _____ |
| *Facility: <input type="checkbox"/> Non-contracted Tax ID #: _____ | NPI#: _____ | Contact Person: _____ |
| | | *Phone #: _____ |
| | | *Fax #: _____ |
| If requesting a <u>non-contracted provider/facility</u> , please explain why: _____ _____ | | |
| *Type of Service: Please check only one of the boxes: | <input type="checkbox"/> ASC <input type="checkbox"/> MRI/MRA/CT PET <input type="checkbox"/> PT/OT/ST <input type="checkbox"/> Cosmetic/Reconstructive | <input type="checkbox"/> Elective Outpatient Surgery <input type="checkbox"/> Office Procedure <input type="checkbox"/> Transplant Evaluation <input type="checkbox"/> DME <input type="checkbox"/> Medication |
| | | <input type="checkbox"/> Prosthetics/Orthotics <input type="checkbox"/> Home Health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other _____ |
| ▶ Clinical Information: | | |
| *Diagnosis Code: _____ | Diagnosis: _____ | |
| *Procedure/Service Requested: _____ | <input type="checkbox"/> CPT Code: _____ | <input type="checkbox"/> HCPCS Code: _____ |
| Procedure/Service Description: _____ | | |
| Number of visits: _____ | Duration: _____ | |
| Frequency of visits: _____ | Number of previous visits: _____ | |
| *Is supporting Clinical Information Attached? | Yes No - Please summarize clinical information below | |

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Appendix I, Sample CMS 1500 Claim form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#) | | | | | | | | | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | | | | | | | |
| CITY | | | | | STATE | | | | | 7. INSURED'S ADDRESS (No., Street) | | | | | 8. RESERVED FOR NUCC USE | | | | |
| ZIP CODE | | | | | TELEPHONE (Include Area Code) () () | | | | | CITY | | | | | STATE | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | 12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # if yes, complete items 9, 9a, and 9d. | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | b. OTHER CLAIM ID (Designated by NUCC) | | | | |
| b. RESERVED FOR NUCC USE | | | | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # if yes, complete items 9, 9a, and 9d. | | | | |
| c. RESERVED FOR NUCC USE | | | | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | 10d. CLAIM CODES (Designated by NUCC) | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | | | | | 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. | | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. | | | | | 15. OTHER DATE MM DD YY QUAL. | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | 17a. NPI | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ | | | | | A. _____ B. _____ C. _____ D. _____ | | | | | 22. RESUBMISSION CODE ORIGINAL REF. NO. | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | |
| E. _____ F. _____ G. _____ H. _____ | | | | | I. _____ J. _____ K. _____ L. _____ | | | | | 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPIC/ Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. # | | | | | 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> | | | | | 26. PATIENT'S ACCOUNT NO. | | | | | 27. ACCEPT ASSIGNMENT? (For govt. assigns, see book) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | 28. TOTAL CHARGE \$ | | | | |
| 28. TOTAL CHARGE \$ | | | | | 29. AMOUNT PAID \$ | | | | | 30. Rev'd for NUCC Use | | | | | 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | 33. BILLING PROVIDER INFO & PH # () | | | | | SIGNED _____ DATE _____ | | | | |
| SIGNED _____ DATE _____ | | | | | a. NPI | | | | | b. NPI | | | | | c. NPI | | | | |

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Appendix J, Sample of Claims Appeal Form



Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Claims Appeal Form

Providers must request Claims Appeal within 60 days from the date of the Explanation of Payment (EOP).

| Provider Information: | | | |
|------------------------------|--|-----------------------|--|
| Provider Name | | | |
| NPI | | TIN | |
| Contact Person | | Contact Number | |

| Claim Information: | | | |
|----------------------------------|--|--------------------------------|---|
| Member Name | | Medicaid or Medicare ID | |
| Number of Claims | | Number of Pages Sent | |
| Claim ID | Date(s) of Service | Authorization Number | |
| | | | |
| Reason for Appeal/Denial: | <input type="checkbox"/> Denied for Non-covered Benefit <input type="checkbox"/> Denied for Timely Filing | | <input type="checkbox"/> Denied for No Auth <input type="checkbox"/> Other |

Explanation for Appeal:

Please attach any additional information and any supporting documentation. Indicate an authorization number, if applicable. Please be advised that corrected claims are not appeals.

Submit Claims Appeal Form:

| | |
|---------------------------|--|
| Fax | 1-877-809-0783 |
| Mail | Cigna-HealthSpring CarePlan Attn: Appeals and Complaints Department PO Box 211088, Bedford, TX 76095 |
| Electronic Appeals | visit our HSConnect provider portal via our website at careplantx.com |

For assistance, please call Provider Services at 1-877-653-0331.

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H8423_15_29310 PR

Appendix K, Payment Dispute Form



Payment Dispute Form

Number of pages (Including Cover Sheet): _____

Provider Name: _____ NPI/TIN: _____ Date: _____

Providers have the option to use 1 form per Member or list multiple Members on the same form. **For Nursing Facility claim requests, please check here.**

| | Member ID: | Member Name: | Claim Number(s): | Date(s) of Service: | | Billed Amount: | Reason Code(s): | Reason Codes: |
|----|------------|--------------|------------------|---------------------|-----------|----------------|-----------------|--------------------------|
| | | | | Start Date: | End Date: | | | |
| 1. | | | | | | | | 1. Underpaid / Overpaid |
| 2. | | | | | | | | 2. Authorization Issues |
| 3. | | | | | | | | 3. Modifier Issues |
| 4. | | | | | | | | 4. Denied As A Duplicate |
| 5. | | | | | | | | 5. Incorrect Coding |
| 6. | | | | | | | | 6. Applied Income (AI) |
| 7. | | | | | | | | 7. RUG Level Change |
| 8. | | | | | | | | 8. Other Reasons |
| 9. | | | | | | | | |

Comments:

- 1.) For claims that are partially paid or denied, please re-submit this form with supporting documents.
 - a. Copy of the Remittance Advice
 - b. Copy of the Original Invoice (if applicable)
 - c. Other requesting documents
 - 2.) To send completed Claims Adjustment Form, please fax to **1-877-809-0783**, e-mail to **Claims_MMP_Medicaid@HealthSpring.com** or mail to:

Attention: Cigna-HealthSpring Payment Dispute Unit
P.O. BOX 211088
Bedford, TX 76095
- For any questions, please contact Provider Services at: **1-877-653-0331**.

Payment Disputes are requests to review a previously adjudicated claim. This form is not to be used for corrected claims, or claim appeals. A Payment Dispute request from a PAR/NON-PAR Provider must be filed within 120 days (for Medicaid plans) and 60 days (for Medicare-Medicaid Plans (MMP)) from the date of the disposition or the remittance of Explanation of Payment (EOP). Out of State providers must file within 365 days.

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Appendix L, Member Acknowledgement Statement

I understand that, in the opinion of _____ **[Provider Name]** _____, the services or items that I have requested to be provided to me on _____ **[Date]** _____ may not be covered under Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health-insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Patient Signature: _____

Date: _____

Appendix M, Private Pay Agreement

I understand that _____ **[Provider Name]** _____ is accepting me as a private pay patient for the period of _____ **[Enter Dates]** _____ and I will be responsible for paying any services I receive. The provider will not file a claim to Medicaid or Cigna-HealthSpring for services provided to me during this period.

Patient Signature: _____

Date: _____

Appendix N, Clinical Practice Guidelines



Cigna- HealthSpring has adopted evidence based clinical practice guidelines as roadmaps for healthcare decision-making targeting specific clinical circumstances. Cigna-HealthSpring promotes the use of clinical practice guidelines to:

- ✓ Define clear goals of care based on the best available scientific evidence
- ✓ Reduce variation in care and outcomes
- ✓ Provide a more rational basis for clinical management of some conditions
- ✓ Comply with accreditation standards and regulatory expectations

The table below contains the clinical practice guidelines approved by Cigna-HealthSpring's Clinical Guidelines Steering Committee., as well as links to the websites with the most current version of the guideline.

| Topic | Name of Guideline | Organization / Web Address | Approval Date |
|--|---|---|----------------------|
| Acute Stress Disorder or Post Traumatic Stress Disorder | Guideline Watch (March 2009): Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post Traumatic Stress Disorder | American Psychiatric Association http://psychiatryonline.org | January 28, 2015 |
| Antithrombotic Therapy and Prevention of Thrombosis | Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines | American College of Chest Physicians http://journal.publications.chestnet.org/article.aspx?articleID=1159399 | January 28, 2015 |
| Bipolar Disorder | Guideline Watch: Practice Guideline for the Treatment of Patients with Bipolar Disorder, 2nd Edition | American Psychiatric Association http://psychiatryonline.org | January 28, 2015 |
| Cholesterol Management in Adults | ICSJ Health Care Guideline: Lipid Management in Adults; Thirteenth Edition | Agency for Healthcare Research and Quality http://www.guideline.gov/content.aspx?id=36062&search=lipid+management#top | January 28, 2015 |
| Coronary Artery Disease | Diagnosis of Stable Ischemic Heart Disease; November 2012 | American College of Cardiology American Heart Association, et al http://annals.org/article.aspx?articleid=1392193 | January 28, 2015 |
| Chronic Heart Failure in Adults | 2013 ACCF/AHA Guideline for the Management of Heart Failure | American College of Cardiology American Heart Association http://circ.ahajournals.org/content/128/16/e240.full.pdf+html | January 28, 2015 |
| Chronic Obstructive Pulmonary Disease | Chronic Obstructive Pulmonary Disease | Agency for Healthcare Research and Quality http://www.guideline.gov/content.aspx?id=38897 | January 28, 2015 |
| Community-acquired Pneumonia in Adults | Infectious Diseases Society of America / American Thoracic Society Guidelines on the Management of Community-Acquired Pneumonia in Adults (2015 update in progress) | Infectious Diseases Society of America / American Thoracic Society http://cid.oxfordjournals.org/content/44/Supplement_2/S27.full.pdf | January 28, 2015 |

Provider Services Department:

1-877-635-0311

**[https://www.cigna.com/medicare/
healthcare-professionals/tx-mmp](https://www.cigna.com/medicare/healthcare-professionals/tx-mmp)**

