Welcome to Cigna Behavioral Health

Section 1

We are pleased to include you in the Cigna Behavioral Health. Inc. ("Cigna Behavioral Health") network, where quality care is our highest priority. Because we understand the success of a behavioral health care program depends on the caliber and integrity of its providers, we are highly selective and conscious of quality as we develop our network.

We also understand that a stable provider panel facilitates our goal of consistent and superior customer service. For that reason, we seek to build strong, long-standing relationships with our providers. Our policies and protocols have been developed to minimize time-consuming administrative activities, so you can spend more time providing superb service.

The Cigna Behavioral Health Provider Guide (also known as the Cigna Behavioral Health Medical Management Program in your Agreement) provides the information necessary to fulfill your contractual obligations, including the referral process, care management services, and claims information.

About Cigna Behavioral Health

We provide behavioral care benefit management, employee assistance and work/life programs to consumers through health plans offered by United States employers of all sizes, national and regional HMOs, Taft-Hartley trusts and disability insurers. With headquarters in Eden Prairie, MN, we operate four care management centers around the United States in support of a national network of more than 80,000 independent psychiatrists, psychologists and clinical social workers and more than 10,000 facilities and clinics.

Our core values have remained the same since our founding in 1974:

Compassion: We create a caring environment in which our employees feel good about working here. This translates into a compassionate voice on the phone when participants and providers call us for help. It is also a key reason why you'll find our turnover is much lower than that of our competitors.

Expertise: We use Six Sigma methodologies to make technical improvements, and promote the ongoing education of our employees with tuition reimbursement, seminars, and other activities that help us stay on the leading edge of behavioral care.

Service: We treat service performance as a clinical issue, not just as a numbers game. Answering a phone call on the first ring with a compassionate, caring voice, and making sure that the caller gets the necessary help the first time is one of our strengths.

Integration: We are not only open to working with others in providing top-level behavioral health programs; we collaborate with a range of other organizations in order to get the best results for a range of customer needs. Having the ability to integrate our programs and services effectively and efficiently with others has not only led to our organization being among the fastest growing in the industry, it has been key in the development and understanding of holistic care and the benefits of 'treating the whole person,' mentally as well as physically.

Professional Network

Section 2

Practitioner Selection

The foundation of the Cigna Behavioral Health approach to quality management is identifying, credentialing, and contracting with providers who deliver care consistent with our clinical quality program. Our goal is to establish and maintain a panel of providers whose standards of practice individually and collectively are consistent with Cigna Behavioral Health's standards.

The Cigna Behavioral Health network is comprised of physicians, psychologists, nurse practitioners, physician assistants, and masters level clinicians. In order to be considered for inclusion, all individual providers, with the exception of physician assistants, must be currently licensed to practice independently in the state(s) in which they will be contracted with Cigna Behavioral Health and maintain a minimum practice of 24 clinical hours per week, including both outpatient and/or inpatient work.

If the practitioner provides services from a home-based office, the office must meet the following requirements:

- The office must be used solely for practice.
- If in-person treatment is occurring, the home office must have a separate entrance from the living area.
- The office space and any other patient areas (treatment rooms, waiting rooms, bathrooms, etc.) must be separate from the living area.
- The office space and any other patient areas (treatment rooms, waiting rooms, bathrooms, etc.) must be clean, and free of smoke, animals (except service) and personal effects.
- If in-person treatment is occurring, the office must have a waiting room separate from the living area that offers privacy from the treatment room during appointment hours.
- The office telephone line must be on a separate line from the residential line.
- Medical records must be secured in a locked file and/or room, out of sight of patients.

Providers selected for participation must successfully complete a thorough screening, contracting, and credentialing process. All information obtained in the credentialing process is confidential, except as otherwise provided by law. Cigna Behavioral Health recredentials each contracted practitioner every three years.

If the practitioner meets the credentialing criteria and a contract is extended, the Agreement will include all lines of business. Cigna Behavioral Health utilizes eSignature for contracting. Practitioners will receive the contract packet via email in order to electronically sign and return the Agreement. Cigna Behavioral Health will execute the Agreement via an electronic signature and send the executed agreement back to the practitioner via email. The Cigna Behavioral Health Agreement is specific to practitioner, rather than to location or Tax Identification Number. Practitioners must treat all Cigna Behavioral Health participants equally and must behave as contracted at all service locations.

Supplementing those processes, a review of medical records of high volume practitioners occurs annually. Semiannually, Cigna Behavioral Health reviews all reported complaints about providers and adverse events to detect any patterns or trends that might require investigation. Licensing board and Medicare/Medicaid actions are monitored monthly.

Practitioner Credentialing

Cigna Behavioral Health uses the Council for Affordable Quality Healthcare's (CAQH) credentialing application to assist in our network credentialing process. This application is used for credentialing new behavioral health providers to the Cigna Behavioral Health network and to recredential our current network behavioral health providers.

If you have not used CAQH before, simply access their online application at www.CAQH.org/cred and complete the application. Once you have finished, you will be required to attest that your information is complete and accurate. Please also be sure to authorize Cigna Behavioral Health for access to your data so that the credentialing or recredentialing process can continue.

After the CAQH application is completed, providers will need to reattest to the information originally submitted (or make any necessary updates) every 120 days. When providers consistently reattest through CAQH, no additional outreach from Cigna will be necessary at the time of recredentialing.

However if this information is not reattested consistently, Cigna will contact the provider six months prior to the recredentialing date. A minimum of two outreach attempts will be made to encourage the provider to reattest. If the provider has failed to respond after these attempts, pre-termination notice will be sent by certified mail in accordance with state compliance laws and Cigna contracting guidelines.

Please also note that it is very essential that our network providers keep their demographic information (addresses, telephone numbers and email addresses) up-to-date in the CAQH application and with Cigna Behavioral Health. This will ensure that we can contact you promptly regarding any recredentialing issues.

Behavioral health providers who have questions or need help with completing their CAQH application can contact CAQH directly:

Contact information for CAQH

Help Desk: 888.599.1771

Fax: 866.293.0414

Website: www.CAQH.org/cred

Practitioner Rights and Responsibilities

Contracting and Initial Credentialing

Prospective providers can apply directly online with our enhanced Cigna Behavioral Health Provider Application. Cigna Behavioral Health will respond by email within six weeks after reviewing the application.

If you have any additional questions or concerns, you may also call our Provider Services Center, at 800.926.2273.

If you practice in Minnesota, North Dakota or western Wisconsin:

In these markets, Cigna's behavioral network represents an alliance between Cigna and HealthPartners. For contract consideration, please complete the HealthPartners Behavioral Health Contract Inquiry at https://www.healthpartners.com/provider-public/forms-other/contracting-inquiry/provider-type.html.

If you practice in Missouri:

For the status on where you are in the credentialing process, please email us at BehavioralContracting@cigna.com. Please include your name and Tax Identification Number.

Recredentialing and/or Access to Credentialing/Recredentialing File

If you have any questions about recredentialing, please use the contact information below.

At any time, Cigna Behavioral Health practitioners may request, in writing, information contained in the practitioner file that was submitted in support of the practitioner's credentialing/recredentialing application. The request for

review is to be directed to the Credentialing department (see below). Cigna Behavioral Health will make arrangements for this review as soon as possible after receiving the request.

- Phone: 800.926.2273
- Email: BehavioralHCPEnrollment@Cigna.com
- Mail: Cigna Behavioral Health - Attn: Credentialing
  11095 Viking Drive, Eden Prairie, MN 55344

Credentialing/Recredentialing Discrepancies

If significant discrepancies are identified between the information on your application and information obtained in the external verification process, you will be contacted within five days of the discovery, and given the opportunity to clarify or explain the discrepancies.
In this situation, Cigna Behavioral Health will request a written response, due within 30 days. Your response and the recommendations of the Provider Relations department will be forwarded for review to the Credentialing Committee. The Committee has authority to approve or disapprove your inclusion in the network. You will be notified in writing, within 30 days, of the Committee's final decision if you are being credentialed for the first time. You will not receive any notice if you are being recredentialed.

Practitioners Right to Correct Erroneous Information

You have the right to correct erroneous information submitted by another party or to submit a more detailed explanation of the information you had previously sent. However, the right to correct information does not apply to the Credentialing Questionnaire, because you attested to the correctness of the information upon submission.

Specialty Privileging

When you complete the provider application you will be asked to identify those specialties in which you consider yourself a specialist. Each month a Specialty Privileging audit is done on a random sampling of practitioners who were accepted into the network the previous month. Those practitioners selected for the audit will be asked to submit documentation that supports their specialty selections. Documentation may include evidence of formal education in a particular specialty, an accumulation of CEUs in that specialty area, or a resume that demonstrates extensive experience in that specialty.

Please be aware that any and all changes associated with your practice, such as change of address, hours, phone number, specialty, additional certification, insurance, etc., must be reported to Cigna Behavioral Health as soon as possible. These changes should be submitted within 30 days. Visit the "Working with Cigna" section of your secure dashboard. The easy-to use online forms can be found within the Profile Information area.

Appeal of Suspension or Termination of Agreement Privileges

If a practitioner is notified that network participation has been suspended or terminated by Cigna Behavioral Health, the practitioner may contact the Manager of Network Operations identified in the notification or the Provider Relations department to discuss the suspension or termination.

There is the option of a formal appeal of the suspension or termination of Agreement privileges. The practitioner may request reconsideration by sending a letter to the Manager of Network Operations. This letter must describe the reason for requesting reconsideration and include any supporting documentation. The practitioner has thirty (30) days from the receipt of the suspension or termination letter to make a written request for reconsideration. Cigna Behavioral Health's Credentialing Committee Appeal Panel will review the appeal at its next monthly meeting and issue a written notification of the outcome to the practitioner. The Appeal Panel is composed of at least three

clinicians, none of whom were involved in the decision being appealed. One of the clinicians will be from the same discipline as the appealing practitioner.

The practitioner and/or their representative may choose to attend the meeting either in person or by conference call. They must notify Cigna Behavioral Health of their desire to participate at least three (3) working days prior to the meeting so appropriate arrangements can be made. The provider will be notified within five (5) working days of the committee's decision, including the reason for the decision.

A practitioner who is dissatisfied with the decision of the Credentialing Committee may pursue arbitration as outlined in the *Dispute Resolution Procedure* section of the Participating Provider Agreement. A sixty (60) day time limit exists for the pursuit of arbitration, following the decision rendered by the Credentialing Committee or Appeal Panel. Practitioners who contact the American Arbitration Association should request all documentation be forwarded to:

General Counsel
Cigna Behavioral Health, Inc.
11095 Viking Drive, Suite 350
Eden Prairie, MN 55344

The Participating Provider Agreement renews automatically every year on the anniversary date of the Agreement. Either Cigna Behavioral Health or the practitioner can choose not to renew the Agreement with a written sixty (60) day notice to the other party. For non-renewal of your Agreement privileges, there is no right of appeal.

In those states where there are laws regulating the appeal process, the state law supersedes this process

Frequently Asked Questions

I am moving and need to change my address or I am changing my Tax Identification Number or legal name.

These changes should be submitted to Cigna within 30 days. Log in to Cigna for Health Care Professionals (CignaforHCP.com) > Working with Cigna > Update Provider Information.

Mail or Fax:	Online:
Network Operations Fax # 860.687.7257	Cigna for Health Care Professionals website (www.CignaforHCP.com)
Cigna Behavioral Health	
11095 Viking Drive, Suite 350	
Eden Prairie, MN 55344	

If you are moving to another state, or leaving a group practice that contracts with Cigna Behavioral Health, your agreement/participation at your old location will be terminated. You must contact the Provider Relations department for your new location so that a new contract can be prepared.

I want to update my self-introduction

Complete the Provider Self-Introduction Form (see Appendix D) and email it to Cigna Behavioral Credentialing at CELTeam@Cigna.com.

Why is money being withheld from my reimbursement checks?

The reduction for backup withholding is a reflection of taxes withheld due to instruction from the Internal Revenue Service. You will need to contact our Accounts Payable department at 800.433.5768 to obtain the forms needed to correct any discrepancy. All other questions should be directed to Provider Services at 800.926.2273.

I want to obtain information about MCG Behavioral Health Guidelines or The ASAM Criteria *(f/k/a Level of Care Guidelines)*.

Visit us online at the Coverage Policies page, see *Supporting Behavioral Websites*.

I would like a copy of my Cigna Behavioral Health provider agreement.

You may either mail or fax a request for a copy directly to Network Operations (see address above)

I want to terminate my agreement with Cigna Behavioral Health.

Our agreement permits you to terminate annually on renewal, however, Cigna Behavioral Health, in its discretion, may permit you to terminate earlier, but in no event with less than 90 days' notice. Send your written request for termination by certified mail to the Provider Relations department at your Regional Care Center (see Appendix A).

I received a termination notification of my Cigna Behavioral Health provider agreement and would like to appeal this decision.

Address a letter of appeal to:

All Practitioners except-
California Practitioners

Network Operations
Cigna Behavioral Health, Inc.

11095 Viking Drive, Suite 350
Eden Prairie, MN 55344

California Practitioners

Provider Relations Department
Cigna Behavioral Health of California, Inc.
400 North Brand Boulevard
Glendale, CA 91203

I have not been receiving any referrals from Cigna Behavioral Health.

Practitioner selection is based on participant preference and practitioner's specialty, geographic proximity, and availability. If you have any further questions, contact your Provider Relations department.

Most Important Reasons to Contact Your Provider Relations Department

To limit or stop referrals for a period of time.
To add/change a specialty or service.
To ask specific question(s) in reference to your agreement.

Should you have further practitioner network questions, please refer to (see Appendix A) to contact your Provider Relations department.

Case Management Program

Section 3

Identifying the Cigna Behavioral Health Participant

Establishing participant eligibility for benefits prior to initiating treatment is essential to ensure claim payment. Participants are not required to obtain prior benefit authorization for routine outpatient care, including diagnostic or initial treatment sessions. Participants can visit the online Provider Directory at www.cigna.com to search for practitioners or can contact us through the mental health and substance use telephone number on their medical identification card. However, coverage for any higher level of care must be preauthorized. Practitioners are responsible for obtaining prior authorization for non-routine outpatient care as well as for all higher levels of care. The practitioner may not bill the participant for care for which prior authorization was not obtained, beyond applicable coinsurance/copayment and/or deductible.

Not verifying eligibility and benefit coverage can result in an Administrative Denial, whereby the practitioner must hold the participant financially harmless if the practitioner was aware of or failed to determine the participant's coverage. If a participant does not have a health care identification card, ask the participant for the information below, then log in to Cigna for Health Care Professionals (CignaforHCP.com) to verify eligibility and benefits for the participant, or call Cigna Behavioral Health.

Participant Information	Participant Name
	ZIP Code
	Date of Birth
	Subscriber ID #
Plan Subscriber Information	Name
	Participant Number
	Subscriber ID #
	Date of Birth
	ZIP Code

Participants enrolled in PPO, OAP, and HMO plans may select a practitioner from a network Provider Directory and are not required to secure prior benefit authorization from Cigna Behavioral Health for routine outpatient services. Preauthorization of coverage and case management of inpatient and residential services for PPO, OAP, and HMO participants *are still required* and must be obtained by the practitioner. Preauthorization for partial and intensive outpatient programs (IOP) is dependent upon the individual's policy. The implementation of federal parity laws in 2010 has resulted in some policies not requiring authorization for partial or IOP. A Cigna Behavioral Health representative can help you determine if preauthorization is required for your patient's benefit plan. Benefits, coinsurance, claim information, and the claims filing address are prominently listed on the participant card.

A practitioner contracted with Cigna Behavioral Health must treat all Cigna Behavioral Health participants equally, and must behave as contracted, regardless of service location. You may not require that Cigna Behavioral Health participants sign self-pay agreements prior to providing covered services to them, unless you specifically set forth in detail to the participant and the participant agrees to pay for those specified behavioral care services in writing prior to the delivery of those behavioral care services. Nor may you charge Cigna Behavioral Health participants out-of-network rates. Please refer to your Cigna Behavioral Health Participating Provider Agreement for additional information.

Scheduling Appointments

Cigna Behavioral Health has adopted the below access standards based on industry standards, and our appointment access standards now include office wait times. In addition, participants should be seen within the timeframes listed below based on the severity of their clinical presentation.

- Post-discharge from inpatient care – Within 7 calendar days
- Emergent – Life threatening – appointment to be within six hours
- Urgent non-life threatening – As soon as possible but not to exceed 48 hours
- Initial routine – Within 10 business days
- **Follow-up routine care within 30 calendar days**
- EAP standard – Within 2 business days
- Office wait time – 15 minutes or less

Practitioners are asked to make every effort to ensure compliance by seeing participants within these access standard timeframes.* Practitioners who are unable to schedule a participant visit within the access standard timeframes should immediately refer the participant to the online practitioner directory or contact Cigna Behavioral Health through the mental health and substance abuse telephone number on their card for alternative referral.

Answering machine/voicemail greetings

It is expected that network practitioners have the capability of 24-hour access for participants in crisis and that answering machine greetings contain clear instructions for accessing care in the event of a crisis. General referrals to emergency room settings for all access standards other than non-life threatening and life-threatening emergencies are not considered to be evidence of appropriate crisis coverage.

It is also expected that your outward greeting communicate message response time frames, e.g. all calls will be returned within 24-48 hours.

*State and/or Federal requirements will override these standards when applicable.

Case Management Process

You can review a list of procedures requiring prior authorization and submit for prior authorization using the appropriate form on the Cigna for Health Care Professionals website, or by calling the number on the back of your patient's ID card. Additional clinical information may be requested before authorization can be given. All documentation should be submitted immediately to help avoid delays. If all necessary information is not provided, Cigna may deny the coverage request for authorization of an admission, procedure, or service.

Outpatient Care

Participants are not required to obtain prior benefit authorization for routine outpatient care services. Routine outpatient services should include an evaluation for individual, couple, family and/or group therapy, plus a medication evaluation. When participants access providers directly, it is important to ensure benefit coverage and to verify eligibility prior to administering services to participants in plans managed by Cigna Behavioral Health, since

practitioners are contractually prohibited from billing participants. Eligibility and benefits may be verified by logging in to CignaforHCP.com. The participant's health care identification card lists the appropriate Cigna Behavioral Health telephone number (Customer Service at 800.926.2273 can provide information in the event of uncertainty regarding the appropriate number to call for benefit eligibility.)

Practitioners are contractually prohibited from billing participants for non-authorized care.

The clinical Case Management staff is trained to assess disease states and to coordinate care between the participants' employee assistance program, disability management vendor, and medical plan. We work to focus on the whole picture so that we may have the greatest positive impact on the clinical outcome ensuring, through utilization management activities, that continued authorization is based on the appropriateness of care provided. To understand our Case Management process and philosophy, it is important to recognize the intrinsic role of the Triage Clinicians, Care Coordinators, and Personal Advocates.

Triage

Cigna Behavioral Health believes that any triage assessment must, at a very minimum, include an evaluation of risk and lethality as well as the possible use and/or abuse of alcohol and other substances, including prescribed medications. The triage function focuses on interventions that will address the immediate crisis. Our triage team is centralized, providing 24/7 service.

Facility-Based Treatment

Requests for benefit authorization for inpatient or other levels of facility-based treatment are considered within a patient's available benefit coverage and in the context of the MCG Behavioral Health Guidelines or The ASAM Criteria®. Preauthorization of coverage by the practitioner is required for all facility-based services, with the exception of partial hospitalization and intensive outpatient programs, when applicable. Depending upon the individual's benefit plan, preauthorization of partial hospitalization and intensive outpatient program service may or may not be required. Cigna Behavioral Health's clinical staff is available 24 hours per day, 7 days per week to review and authorize coverage. If it is determined that medical necessity is met for the requested level of care, Cigna Behavioral Health will arrange admission to a participating facility and specify the participating physician to treat the participant.

The Care Advocacy Program philosophy is to marshal resources and to advocate for participants, with a goal of returning them to the highest possible level of functioning as soon as clinically indicated. Designated Case Management interventions are designed to add value to each case. The Case Manager's ability to manage each case with varying levels of appropriate clinical intensity is one of our greatest strengths.

Emergency Admissions

If the acuity of the participant's condition does not allow for preauthorization of coverage, contact Cigna Behavioral Health as soon as possible. Please be prepared to provide the following information to the Cigna Behavioral Health staff:

- Participant's name, age, and participant identification number.
- History, diagnosis, indications, and nature of the immediate crisis.

- Alternative treatment provided or considered.
- Treatment goals, estimated length of stay, and discharge plans.

If the clinical indicators for hospitalization are unclear based on prudent layperson guidelines or the MCG Behavioral Health Guidelines or The ASAM Criteria®, staff may request additional information or consult a Physician Reviewer. If coverage for hospitalization is then authorized, the staff will arrange the admission. A Case Manager will then conduct regular, ongoing reviews with the hospital staff.

Referrals

Occasionally, it may be necessary for a practitioner to refer a participant outside of his or her practice. A practitioner should search the provider directory or contact a Cigna Behavioral Health Case Manager for referral to an appropriate Cigna Behavioral Health participating practitioner.

Medication

Non-prescribing practitioners who believe medication should be considered can search the provider directory or contact a Cigna Behavioral Health Case Manager for referral to an appropriate Cigna Behavioral Health practitioner. The practitioner can offer the participant the name and phone number of an appropriate prescriber. The participant may then contact the prescriber for an appointment. When medication is prescribed, health plan participants should have prescriptions filled at an authorized health plan pharmacy.

Coaching and Support Programs

Cigna offers six Coaching and Support (C&S) programs to help individuals initiate and engage in behavioral treatment.

The six programs are; C&S-Substance Use, C&S- Opioid and Pain Management, C&S-Autism, C&S-Parent and Families, C&S-Eating Disorder, and C&S- Intensive Behavioral Case Management.

Cigna Case Managers, specially trained in coaching individuals with mental health and substance use disorders, utilize a motivational interviewing approach focused on decreasing both internal and external barriers that may be preventing the individual from initiating and/or engaging in treatment or recovery activities. This approach allows for each program to meet the individual's unique needs

A unique program we offer is Changing Lives by Integrating Mind & Body (CLIMB).This program provides individual and group coaching services to participants who are struggling to cope when living with a chronic physical or emotional condition. The program uses a cognitive behavioral approach based on identifying and improving thinking patterns which cause unhealthy behavior and negative emotions.

Buprenorphine Treatment

Buprenorphine treatment is a modality for outpatient office based Medication Assisted Treatment of opiate use disorders. We have Cigna Case Managers that are able to partner with individuals on MAT in order to enhance adherence to this treatment. Cigna Behavioral Health considers outpatient opiate treatment with Buprenorphine to be potentially eligible for benefit. Both the induction phase of treatment and ongoing medication management are

considered to be routine services and do not typically require prior authorization by Cigna Behavioral Health.

Testing

Generally, clinical review for psychological/neuropsychological testing for covered diagnoses will not be required. There may be certain situations where a review will be required such as for a specific customer/account benefit plan. Testing related to custody evaluations, rehabilitation, vocational counseling, or school evaluations are generally not covered. Please call the number on the back of your patient's ID card prior to confirm benefits and eligibility.

Autism Spectrum Disorder and Applied Behavior Analysis

Prior authorization is typically required for the assessment and treatment of applied behavior analysis (ABA). If you are treating a participant with Autism spectrum disorder please call the number on the back of the participant's plan identification card to confirm eligibility and benefits. Benefit coverage for Autism spectrum disorder and ABA varies by benefit plan and due to state mandates. In most cases your request will be referred to the autism-Coaching and Support Team for discussion of a customized treatment plan. To learn more about our autism team and how to make a request for ABA services, refer to our Autism Information and Resources page. Please refer to your Participating Provider Agreement, Exhibit A for your fee schedule and a listing of autism spectrum disorder-related services eligible for reimbursement. Please refer to Appendix F for information about Cigna Behavioral Health's Specialty Networks, including autism assessment and treatment.

Cigna Behavioral Health's Compensation Promotes Quality of Care and Utilization Management*

(New Jersey practitioners, please refer to the Medical Management Program – Provider Guide, Section "New Jersey" for state-specific information.)

Cigna Behavioral Health compensates health care practitioners in a manner intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of medical services. Cigna Behavioral Health reinforces this philosophy through utilization management decisions by its Medical Directors, Physician Advisors, and Case Management staff. Cigna Behavioral Health employees are encouraged to promote appropriate utilization rather than under-utilization of health care services.
The same criterion applies for staff eligible to receive additional payments based on their performance. Cigna Behavioral Health employees and consultants receive no financial incentives or rewards to deny coverage of medically necessary care. Cigna Behavioral Health offers no incentives for UM decision-makers for underutilization of care.

Coverage Denials*

(California practitioners: please refer to the Medical Management Program – Provider Guide, Section "California" for Coverage Denial information.)

For clinical cases under review resulting in an adverse determination (coverage denial) following the peer-to-peer review, a review of the decision is available with a physician not previously involved in the case. The appeal review is with a Cigna Behavioral Health-contracted, board certified psychiatrist or doctoral-level psychologist, and may be done on an expedited basis, if the situation is deemed urgent and the participant is still in that level of care, or on a standard basis, where more information such as the medical record or a summary of treatment may be made available. An appeal must be submitted within 180 calendar days from the claim denial.

A participant, the participant's delegate, or provider on behalf of a participant, who is dissatisfied with the outcome of the appeals determination, may file an appeal by following the health plan's, or, in some instances, the state's, external appeals process. Many states offer an expedited process if the participant feels the situation is urgent and the participant is still in that level of care. The Case Manager assigned to the case is able to provide information regarding the extent of appeals available.

All appeals are reviewed and determinations made by board certified psychiatrists or board certified PhD-level psychologists. If an appeal subsequently overturns an earlier decision, Cigna Behavioral Health will implement the appeal decision and/or process the authorization or claim for payment of services. Decisions are communicated in writing with all adverse determinations and contain the following information:

- The specific guideline on which the determination is based, including the MCG Behavioral Health Guidelines or The ASAM Criteria®;
- The facts and evidence considered; and
- The clinical rationale for the determination

Appeals of Coverage Denials

For clinical cases under review resulting in an adverse determination (coverage denial) following the peer-to-peer review, a review of the decision is available with a physician not previously involved in the case. This first level appeal review is with a Cigna Behavioral Health-contracted, board certified psychiatrist or doctoral-level psychologist, and may be done on an expedited basis, if the situation is deemed urgent and the participant is still in that level of care, or on a standard basis, where more information such as the medical record or a summary of treatment may be made available. A first level appeal must be submitted within 180 calendar days from the claim denial. A second level appeal review may be available to the participant, the participant's delegate or practitioner on behalf of the participant, in those instances when the denial is upheld at first level appeal. For health plan participants, the standard appeal is filed through the health plan's Appeals Committee. For non-health plan participants, the appeal is filed through the Cigna Behavioral Health Central Appeals Unit. It is important to note that Appeals Committees are for the purpose of resolving participant issues. Payment disputes where the participant is held harmless are not eligible for review by the Appeals Committee, unless the practitioner, with a participant's written authorization, requests an appeal on behalf of a participant. A second level appeal must be submitted within 60 days from the receipt of the first level appeal decision letter.

A participant, the participant's delegate, or practitioner on behalf of a participant, who is dissatisfied with the outcome of the Appeals Committee determination, may file an appeal by following the health plan, or in some instances, the state's external appeals process. Many states offer an expedited process if the participant feels the situation is urgent and the participant is still in that level of care. The Case Manager assigned to the case is able to provide information regarding the extent of appeals available.

All levels of appeals are reviewed and determinations made by board certified psychiatrists or board certified PhD-level psychologists. If an appeal subsequently overturns an earlier decision, Cigna Behavioral Health will implement the appeal decision and/or process the authorization or claim for payment of services. Decisions are communicated in writing with all adverse determinations and contain the following information:

- The specific guideline on which the determination is based, including the MCG Behavioral Health Guidelines or The ASAM Criteria®;

- The facts and evidence considered; and
- The clinical rationale for the determination.

Administrative Denial and Appeal

Administrative denials may be issued for a number of reasons, including exhausted benefits, services not covered under the participant's benefit plan, lack of prior benefit authorization for services, and/or benefits exhausted for the contract year. Participants, or providers on behalf of participants, are entitled to appeal administrative denials.

The appeal review of an administrative denial occurs at Cigna Behavioral Health by a Central Appeals Unit Appeals Coordinator.

Practitioner Concerns Related to Administrative Processes

(New Jersey practitioners, please refer to the Medical Management Program – Provider Guide, Section "New Jersey" for more state-specific information.)

Cigna Behavioral Health has a practitioner concern process separate from the administrative or clinical treatment denial and appeal process discussed immediately above. The purpose of this process is to resolve administrative issues. For administrative concerns, please contact Cigna Behavioral Health as follows:

- Call Claim Customer Service (800.926.2273) with any claim-related issues. For California Practitioners, please see Appendix A
- Call the appropriate Regional Care Center for Appeals of Administrative Denials (the telephone number will be in the denial letter).
- Call the appropriate Provider Relations department with any provider agreement or fee schedule-related issues (see Appendix A)

It is the practitioner's responsibility to present supporting documentation to the appropriate Cigna Behavioral Health office. It is Cigna Behavioral Health's responsibility to investigate all issues presented and to respond to the practitioner in a timely manner. Practitioners who are dissatisfied with the resolution of their issue may write to the Director of Health Operations Business Unit, the Regional Care Center Director or the Director of Network Operations, as appropriate to the issue, for a final determination. Practitioners may contact the Provider Advocate team for the correct location to address their concern. Practitioners who continue to be dissatisfied may pursue arbitration as outlined in the section entitled Dispute Resolution Procedure in the Participating Provider Agreement.

If a participant complains to Cigna Behavioral Health about some aspect of care from a practitioner, the practitioner is required to participate in the internal Cigna Behavioral Health complaint resolution process.
If a participant complains to the provider about an administrative issue, the participant should be directed to call the telephone number listed on the participant's health care identification card. For participants residing in California, please refer to Appendix A

Referrals to all Non-Participating Providers and Ancillary Services Including Attending MD Services, Residential Care Facilities and Free-Standing Laboratories

Patients whose benefit plans are administered by Cigna Behavioral Health generally expect that when they choose to seek care from a Cigna Behavioral network participating provider, charges for all related care will be processed at the

in-network benefit level. For this to occur, the patient must be referred to Cigna and/or Cigna Behavioral participating providers, including other practitioners, laboratories and/or facilities. When a patient is referred to a non-participating provider, the patient may incur unexpected financial liability. Patients whose plans include out-of-network benefits are free to choose to use these benefits for services covered under their plan; however, in doing so, these patients will generally incur higher out-of-pocket costs. To ensure that Cigna Behavioral customers are making informed choices when accessing care, you must fully disclose the financial effect of referrals to participating or non-participating providers under their benefit plan, including the referring practitioner financial interests, if any.

Practitioner's Responsibility to Transition Participant Care

Further, for practitioners who are treating participants under a Preferred Provider Organization arrangement, it is Cigna Behavioral Health's expectation that the practitioner will communicate sufficient advance notice of their termination as necessary to promote transition of care, and that they will apprise the participant of the right to continued treatment with the terminated practitioner for up to 90 days post-termination.

In the event of suspension, additional referrals to the practitioner are halted and, depending on the reason for suspension, Cigna Behavioral Health may reassign the practitioner's current participants.

In those states where there are laws regulating the appeal process, the state law supersedes this procedure.

Getting Paid

Section 4

Timely Filing

The Cigna Behavioral Health, Inc. ("CBH") Participating Provider Agreement requires that claims be submitted within 60 days from the date of covered service. The Agreement permits CBH to deny claims submitted beyond that 60 day time period.

CBH gives providers an additional 30 days to submit claims. Therefore, claims that are not submitted within 90 days of the date of covered service will be denied, unless a longer time is permitted by applicable state law, in which case the claim will be denied in accordance with applicable state law.

When CBH or a payor which is financially responsible to pay for covered services provided to CBH participants, is other than primary under applicable coordination of benefits rules, claims must be submitted within three months (90 days) from the date the primary payor's explanation of payment was issued.

If proof of timely filing is required to perfect a claim, such proof would include: an Explanation of Benefits (EOB) from another carrier showing the claim was submitted in error, but in good faith, to that carrier; an account ledger showing the original date submitted; or, an original claim form with the original date submitted or mail receipt indicating the claim was received in a Cigna office within the allotted timeframe.

Providers submitting paper claims **must use the CMS-1500 form when billing for outpatient services, while facilities must use the UB-04 form for inpatient claims and any other higher level of care.** Cigna Behavioral Health defines a 'clean claim' as a claim that has no defect or impropriety, including a lack of substantiating documentation, or particular circumstances requiring special treatment that prevent timely payment from being made on the claim. If additional documentation (i.e., medical records) involves a source outside of Cigna Behavioral Health, the claim is not considered clean.

(New Jersey providers: please refer to the Medical Management Program - Provider Guide, Section "New Jersey," for more detailed information.)

(Texas providers: please refer to the Medical Management Program - Provider Guide, Section "Texas," for more detailed information.)

Claims submitted for services provided in California are not subject to automatic denial if submitted within one (1) year from the date covered services were rendered as mandated.

When Cigna Behavioral Health is not the claims payor, but is responsible for providing and/or arranging for the provision of mental health and substance abuse services, Cigna Behavioral Health will make reasonable efforts to require the payor to make payment to providers within 30 days receipt of a properly completed bill for covered services by Cigna Behavioral Health or its designee. This payment period may be extended if Cigna Behavioral Health or the payor, in good faith, requires additional time to determine responsibility for such billed services.

Cigna Behavioral Health participating providers agree to refrain from duplicate billing within 30 days of submitting a bill for Covered Services to Cigna Behavioral Health or its designee. For additional information, please call Cigna Behavioral Health's Claim Customer Service:
California HMO Participants California Customer Service 800.753.0540
Participants in East Coast Area Claim Customer Service 800.274.7603

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Participants Patients in Southern States Claim Customer Service 800.283.6226
Participants in West Coast Area Claim Customer Service 800.866.6534

Interactive Response System (IVR)

Cigna Behavioral Health's Interactive Voice Response System (IVR) eliminates the need to speak directly with a representative to obtain routine information. This service is available 24 hours per day, 7 days per week, and allows providers to quickly obtain information about:

- Claim status
- Effective coverage dates for subscribers and/or dependents
- Behavioral care benefits
- Status for authorization of benefits
- Application and contract information

The automated system will quickly and accurately respond to touch-tone key or voice queries.
Cigna Behavioral Health's Provider Service Representatives are available during normal business hours (Monday through Friday:7:30am-7:00pm CT).
Cigna Behavioral Health IVR Refer to above phone numbers
Cigna Behavioral Health COB IVR (for participants to call) 800.472.1680

Electronic Claims

Cigna strongly encourages you to submit claims electronically, including EAP and coordination of benefit (COB) claims. Submitting claims electronically is one of the best ways to simplify and streamline the reimbursement process. Cigna's electronic claims program is:

- Fast-we process, within 15 days, all electronic claims that auto-adjudicate.
- Practical-full integration with your billing procedures. Easy setup and implementation.
- Secure-a higher level of data security than is possible with paper-based process.

Efficient-electronic claims typically have fewer errors than paper claims, so more electronic claims auto-adjudicate

Receive and reconcile your payments faster

Improve your office workflow and productivity, and shorten the payment cycle by enrolling in electronic funds transfer (EFT). When used together, EFT and electronic remittance advice (ERA) can help eliminate claims payment paperwork and improve your cash flow – no more waiting for paper checks to clear. To learn more about EFT and ERA, click these links:

- **Electronic Funds Transfer**
- **Electronic Remittance Advice**

Payment Information at your Fingertips

Once you've enrolled in EFT, you can access your remittance reports online the same day you receive your electronic deposit. To learn how to access these reports online, click the link:

- **Remittance Reports**

National Provider Identifier

The National Provider Identifier (NPI) is a unique identification number for use in standard health care transactions. The NPI is a number issued to providers and covered entities that transmit standard HIPAA electronic transactions (e.g., electronic claims, claim status inquiries). In May 2005, the Centers for Medicare and Medicaid Services (CMS) began issuing NPIs to providers that applied and qualified.
The NPI fulfills a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and was required to be used by health plans and health care clearinghouses in HIPAA standard electronic transactions by May 23, 2007. In addition, the NPI:

- Replaces other identifiers previously used by providers and assigned by payers (i.e., UPIN, Medicare/Medicaid numbers)
- Establishes a national standard and unique identifier for all providers
- Helps simplify health care system administration and encourage the electronic transmission of health care information

When you submit claims or encounters electronically, or transmit other electronic transactions, you must include your NPI. Inclusion of the NPI has been a Health Insurance Portability and Accountability Act (HIPAA) requirement since May 2008. Also, the Taxpayer Identification Number (Employee Identification Number or Social Security Number) of the billing provider must be submitted on electronic claims. Cigna is capable of accepting the NPI on standard HIPAA transactions. This approach should not be confused with any guidance specific to Medicare claims requirements. We will notify you when Cigna will no longer accept HIPAA transactions without the NPI.
For general information about the NPI and the NPI application process, visit https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/, at the Centers for Medicare & Medicaid Services web page. To apply online for an NPI, visit nppes.cms.hhs.gov/NPPES/Welcome.do.

Claim Payment with CMS-1500

The claim submission address and the authorization number for field number 23 on the CMS-1500 form are included in the authorization letter. To ensure timely payment, please complete and submit the CMS claim form to the claim payor as indicated on the authorization letter.
Visit our website at cignaforhcp when submitting claims. *No authorization letter is generated for Assessment &*

Referral model EAP cases; please refer to Section 6 EAP.

Claim Payment with UB-04 (CMS-1450)

The authorization letter with referrals provides the claim submission address and the authorization number for field number 63 on the UB-04 (CMS-1450) form. To ensure timely payment, complete the UB-04 as completely as possible with all required information. Attach an itemization of charges and submit to the claim payor as indicated on the authorization letter.

Using the Correct Procedure Codes

Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue). Claims submitted with outdated codes will be denied. The provider must then resubmit the claim(s) with the correct code. For all EAP sessions (including SAP referrals), you should submit your claims utilizing the CPT code 99404.

Using the Correct ICD-10-CM Diagnosis Codes

Claims must be submitted with the correct/current ICD-10-CM Diagnosis codes.
Claims submitted with outdated or incomplete diagnosis codes will be denied. The provider must then resubmit the claim(s) with the correct diagnosis code. A complete ICD-10-CM diagnosis code includes all digits up to two decimal places per the current coding structure in place.

Assignment of Benefits

Cigna Behavioral Health will direct payment to the provider if the participant is a Cigna Behavioral Health participant. Payment is made according to the rate specified in the Cigna Behavioral Health Participating Provider Agreement. Given that Cigna Behavioral health services has many different types of plans, it is important to remember to obtain an assignment of benefits to receive direct payment from Cigna Behavioral Health or the claims payor. To indicate assignment from your client, include either the participant's signature or the notation “signature on file” on line 13 and check the “yes” box on line 27

Copayment, Coinsurance, and Deductibles

Copayment, coinsurance, and/or deductible amounts to be collected from the participant appear on the Remittance Advice/Explanation of Payment (EOP) form that accompanies the claim payment.
Additional information regarding participant benefits may be obtained either through Cigna Behavioral Health's Claim Customer Service or IVR.
No copayment is collected from EAP participants.

Overdue Copayments, Deductibles, and Coinsurance

The provider may not, under any circumstances, charge interest to participants for overdue copayments, deductibles, or coinsurance.

Eligibility

When Cigna Behavioral Health refers a participant, every effort is made to give providers the correct eligibility information.

Self-Paying Participants

The provider must obtain written approval from the participant, in the form of a Self-Pay Agreement, including full financial disclosure, for any services that were denied by Cigna Behavioral Health, or that were not covered services, in advance of those services being rendered. Services not covered by Cigna Behavioral Health include, but are not limited to:

- Late appointment cancellations
- Court-ordered treatment that is outside the scope of routine outpatient care and is determined by Cigna Behavioral Health to be not medically necessary
- Missed EAP appointments
- Services for which the customer elects to not use their benefit plan

Please see Appendix D, which contains an approved Cigna Behavioral Health Self-Pay Agreement. The provider may use a Self-Pay Agreement of their own design; however, all data elements as described in The Self-Pay Agreement must be contained therein. Self-Pay Agreements signed by the participant either at the time of admission to the facility or at the start of outpatient treatment, that reference the possibility of a self-pay arrangement in the future will not be accepted as proof of a self-pay agreement. In these circumstances, the participant must be financially held harmless as per the terms of the provider agreement

(For Maine health, please refer to the Medical Management Program - Provider Guide, Section "Maine")

The Agreement must include the following:

- That the participant is aware of Cigna Behavioral Health's appeal process and declines to appeal.
- A statement that the Agreement applies only to the specific level of care or services the participant is requesting. If the participant moves to a different level of care, an authorization must be obtained or another Self-Pay Agreement signed.

The Agreement is in effect only from the date the participant signs it, until or unless it is rescinded; the Agreement may never be retroactive. Although by signing the Agreement the participant, in effect, waives his/her right of appeal at that time

Coordination of Benefits (COB)

Whenever another group benefit plan is potentially responsible for a portion of the payment, Cigna Behavioral Health requests other insurance information from the participant. To expedite claim payment, participating providers need to request that the participant complete the 'Coordination of Benefits' form (see Appendix B) and submit it with their first claim submission. Updated COB information must be requested yearly or as information changes.
If Cigna Behavioral Health is a secondary payor, the provider should submit the claim to the primary carrier first, and then enclose a copy of the EOB with their claim submission to Cigna Behavioral Health. Cigna Behavioral Health has an IVR telephone line expressly for policyholder/participant updates for COB. If the policyholder/participant has no other insurance, the policyholder/participant can call 800.472.1680 to automatically update their insurance information. If the policyholder/participant does have other insurance, the COB form should be completed as indicated above.

Delays in Claim Payment

Obtaining complete information from the participant and carefully reviewing claim forms to ensure accuracy and completeness can prevent delays in processing. Some common problems (list not all inclusive) that may create delays may include:

- Failure to obtain prior authorization
- Federal tax ID number not included
- Billing address on claim form does not match information on file with Cigna Behavioral Health
- Visits or days provided exceed the number of visits or days authorized
- Date of service is prior to or after the authorized benefit period
- Provider is billing for unauthorized services
- Insufficient itemization of charges
- Participant has exceeded benefits
- Preexisting conditions not covered, specific to an employer plan
- An unauthorized provider rendered services (for example, Cigna Behavioral Health authorized benefits from a PhD but services were rendered by a social worker)
- Mixed services protocol (charges including both medical and behavioral health treatment)
- Explanation of benefits from primary carrier is not attached to the claim when secondary coverage is requested (often referred to as "Coordination of Benefits" or COB, wherein an individual is covered by more than one benefit plan—under your agreement with Cigna Behavioral health, the total recoverable may not exceed the contracted rate).

Claims lacking information may either be returned to the provider for completion before processing or information may be requested directly from the participant on an EOB. If there is not prompt payment for a claim, it may be pending due to one (or more) of the above reasons. In all instances, Cigna Behavioral Health claim staff will pursue resolution of these issues as quickly as possible

Overpayment Recovery Procedure

(New Jersey providers: please refer to the Medical Management Program – Provider Guide, Section "New Jersey," for more specific information.)

(Tennessee providers: please refer to the Medical Management Program – Provider Guide, Section "Tennessee," for more specific information.)

When an overpayment by Cigna Behavioral Health has been identified, Cigna Behavioral Health obtains a refund in one of two ways: either by offsetting payment from future claims, when applicable, or by requesting a refund from the provider who provided services.
In states where applicable, when Cigna Behavioral Health identifies that a cover payment has been made on a participant's claim, Cigna Behavioral Health will reverse that payment, leaving a negative balance in the provider's account.

Providers are requested to repay overpayments directly to Cigna Behavioral Health as outlined in the overpayment notice sent once overpayment is identified.
Based on banking arrangements for specific clients, as well as state mandates, some claims may offset prior to Cigna Behavioral Health receiving the requested refund. When this occurs, any refund received from the provider is returned to the provider with a letter explaining the offset. Until overpayment is resolved, payment on additional claims may be suspended.

For inquiries about the overpayment process, please call the number on the participant's insurance card.

For ASO accounts and states that allow offset:
If the overpayment on the provider's file has not offset within thirty (30) days, an overpayment letter is sent to the provider requesting the refund. If Cigna Behavioral Health does not receive the refund within sixty (60) days, a second refund request letter is sent advising that if Cigna Behavioral Health does not receive the refund within the next thirty (30) days, a third notice will be sent. If the refund is not received within the next thirty (30) days, Cigna Behavioral Health will again attempt to deduct (offset) the negative balance from future payments to be made to the provider.

If at any time we receive the refund from the provider and the overpayment has already been offset, Cigna Behavioral Health will return the check to the provider with a letter advising that the overpayment has been offset.

Explanation of Payments/Benefits (EOB)

Example of a participants' EOBs is provided in Appendix B. Also attached are definitions of the fields on the EOB.

Non-Cigna Behavioral Health Claims

Please note that in some instances claims are submitted to the medical carrier, not Cigna Behavioral Health. The participant's membership card indicates where to submit claims.

Cigna Debit Card Transactions

The Cigna debit card should be used only for "medical care" expenses as defined in Internal Revenue Code section 213(d). Your patients may use their Cigna debit card to pay for eligible Section 213 medical care expenses through their Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA).
When a patient presents a Cigna debit card, the card should not be used for non-eligible medical care expenses, such as cosmetic procedures. When Cigna patients use their debit card for their in-network health care visits, substantiating these claims helps to improve their experience and speed up how quickly you get paid by us.
If the transactions are not eligible per IRS regulation, the patient should be asked to provide a separate/additional form of payment. Additional information about eligible transactions can be found at www.cigna.com/expenses or http://www.irs.gov/publications/p969/index.html. You can also call Cigna Customer Service at 1.800.88Cigna.

Telehealth

Cigna Behavioral Health will pay providers that render telehealth services at the same rate it would pay had these services been rendered through in-person contact.

Products

Cigna Behavioral Health's menu of services includes the provision of mental health and substance abuse services to Cigna HealthCare, including its HMOs, PPO, and Point-of-Service programs. In addition, Cigna Behavioral Health provides behavioral care services, management and employee assistance to many other HMOs and employers nationwide.

Cigna Behavioral Health Services to Cigna HealthCare, Other HMOs and Stand-Alone National Accounts

Health Maintenance Organizations (HMO)

Cigna Behavioral Health manages the mental health and substance abuse benefits for Cigna HealthCare's membership as well as for other HMOs. Cigna Behavioral Health's Regional Care Centers (RCC) manage intake, verify eligibility and benefits, and provide treatment authorization and care management. Some HMO products also include an out-of-network option. Claims are processed by the Cigna Behavioral Health Claims department.

Cigna Preferred Provider Organizations (PPO)

In Cigna's PPO open access product, participants may select any Cigna Behavioral Health practitioner listed in a network Provider Directory. Benefits, coinsurance, and claim information are listed on the participant's ID card. Cigna Behavioral Health does not pay claims for this product.

Stand-Alone Employer Accounts

Some employers contract with Cigna Behavioral Health to manage their behavioral benefits as a 'carve-out' from their general medical coverage. Cigna Behavioral Health's National Care Center (NCC) and, on occasion, a Regional

Care Center, manage intake, verify eligibility and benefits, and provide treatment authorization and Care Management. Cigna Behavioral Health's Claims department or a Third Party Administrator (TPA) process the claims.

Cigna-HealthSpring Medicare
AZ

In accordance with federal laws, the information under this section complements the Cigna Behavioral Health Participating Provider Agreement

Medicare Managed Care

Cigna Behavioral Health practitioners deliver services to Medicare participants enrolled in an HMO Benefit Agreement with Medicare Advantage organizations. The benefits supplied by Medicare Advantage organizations are a Medicare replacement product, rather than a Medicare supplemental plan. A participant has to be enrolled in Medicare and opt to have coverage by a Medicare Advantage organization. Medicare participants are identified by their membership card.

Access to Records and Facilities

Cigna Behavioral Health's contracted practitioners and downstream entities must allow Cigna HealthCare, U.S. Department of Health and Human Services, the Comptroller General, or their designees to audit, evaluate, or inspect any books, agreements, medical records, participant care documentation, and any other additional relevant information that the Centers for Medicare & Medicaid Services (CMS) may require which pertains to any aspect of services rendered to Medicare participants. All records and documents must be maintained for a period of six years. Contracted practitioners and downstream entities must also make available their premises, physical facilities and equipment for the purposes described above.

Confidentiality and Accuracy of Participant Records

Cigna Behavioral Health's contracted practitioners must safeguard the privacy of any information that identifies a particular participant. Information from, or copies of, records may be released only to authorized individuals. Practitioners must abide by all Federal and State laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and participant information. Original medical records must only be released in accordance with Federal or State laws, court orders, or subpoenas.
Cigna Behavioral Health's contracted practitioners must also maintain participant records and information in an accurate and timely manner.

Cigna-Healthspring Medicare
(AL, AR, DC, DE, FL, GA, KS, MD, MO, MS, NC, NJ, PA, SC, TN, TX)

Cigna aligned with HealthSpring in 2012 to assist the growing market of Americans, aged 65 and older, transition from career into retirement. During the following years, the organizations have successfully united under a common mission to improve the health and well-being of our customers.

As part of the Cigna and HealthSpring alignment, Cigna-HealthSpring continues to administer behavioral health benefit services, including claims processing, customer service, medical management and utilization management. Cigna Behavioral Health administers behavioral health care professional network services, including joining and leaving the network, contracting, credentialing and fee negotiations.

Cigna-HealthSpring and Cigna Behavioral Health are committed to providing our customers with the highest quality and greatest value in health care benefits and services.

For additional information about the Cigna-HealthSpring Medicare Advantage Network, including their Provider Manual and Provider Newsletter, please visit their website at: https://www.cigna.com/medicare

For information related to Cigna-HealthSpring's Behavioral Health Unit, please visit their website at: https://www.cigna.com/medicare/healthcare-professionals/bhunit

Transfer of Medical Records

All Cigna Behavioral Health contracted practitioners must have appropriate authorization/release forms and a policy for the transfer of Medical Records. Requests for release of any medical information must include a signed release by the participant or legal representative, and the request must be no more than twelve months old or other time period as may be specified by State laws. Medical records are to be transferred within five to ten working days of receiving a request from a Medicare participant or the participant's legal representative. If the transfer cannot be accomplished within that time period, the participant should be informed by telephone of the reason for the delay, and the date and time of the call should be documented. Medical records are to be packaged and transferred in a manner that protects the privacy of the record in transit.

Expedited requests for the transfer of medical records must be processed in a timely manner that does not interfere or cause delay in the provision of services to the Cigna Behavioral Health participant.

Emergency requests refer to instances where another health care practitioner requires past medical/surgical history on a Cigna Behavioral Health participant to maintain continuity of care. The request should be verified by calling back the practitioner. After verification, medical information may be read over the telephone or faxed to the appropriate location. A notation should be made in the participant's record indicating the information released, and to whom it was released. When possible, a release should be sent to the receiving practitioner to be completed, signed by the participant, and returned to the medical record.

Serving a Diverse Population

No Discrimination Allowed

Cigna Behavioral Health contracted practitioners cannot differentiate or discriminate in the treatment of any Medicare Advantage participant on the basis of health status, race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, handicap or source of payment

Providing Services in a Culturally Competent Manner

All services to Cigna Behavioral Health's Medicare participants must be provided and administered in a culturally competent manner; including those services to participants with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities.

Please contact Cigna Behavioral Health (telephone number located on the participant's ID card) if information or assistance is needed in administering services in the following areas:

- Plan and community support services for 'culturally diverse' participants, including participants with diverse cultural and ethnic backgrounds and the homeless.
- Translator or translation services for non-English speaking participants to meet specific language needs during treatment.
- Availability of health information brochures for participants in various languages.
- Hearing impaired assistance through a relay service.
- Assistance for the visually impaired.

Access must be provided for the physically handicapped. Cigna Behavioral Health will continue to assess this access during practitioner site reviews and as part of the credentialing and recredentialing process.

Complex Care, Follow-Up Care and Self-Care

Cigna Behavioral Health arranges/seeks participant approval to exchange information (including results of health assessments completed in the first 90 days of enrollment) between Medicare Advantage health plans and primary care physicians.

This information will be used for early identification and coordination of care of participants with complex or serious behavioral health conditions.

Cigna Behavioral Health's contracted practitioners must ensure that Medicare participants are informed of specific health care needs that require follow up and that they receive, as appropriate, training in self-care and other measures they may take to promote their own health.

Claims and Encounter Reporting

Reporting of Encounter Data

Cigna Behavioral Health's contracted practitioners who are required to submit encounter data for Medicare must certify that the submitted encounter data is accurate, complete, and truthful to the best of their knowledge. Cigna Behavioral Health in turn will submit this information to CMS. The encounter data must include all data necessary to characterize the content and purpose of each encounter between a Medicare participant and a contracted practitioner or entity.

Claims Processing

Medicare has regulations regarding the timely payment of all claims. In accordance with CMS requirements, Cigna Behavioral Health will ensure that all nonparticipating practitioners' claims are paid within thirty calendar days following receipt of a clean claim and all other claims paid within sixty (60) calendar days. To assure compliance with claims payment regulations, Cigna Behavioral Health submits monthly, quarterly, and annual claim payment reports to Medicare Advantage health plans.

Appeals and Grievance Process

Organization Determinations and Standard Appeals

Cigna Behavioral Health and its delegated practitioners must make an Organization Determination to provide, authorize, deny, or discontinue a Medicare service as expeditiously as the participant's health condition requires (but no later than fourteen calendar days for a standard request, seventy-two hours for an expedited request, or within sixty (60) calendar days for a payment of service request).

If Cigna Behavioral Health's decision is unfavorable, (also called Adverse Organization Determination), the denial must be in writing. If unfavorable, the participant may appeal to the contracted health plan for reconsideration. The maximum time frame for Care Management decisions is now reckoned in 'calendar days', as opposed to 'working days'. Cigna Behavioral Health may extend the time frame by up to fourteen calendar days if Cigna Behavioral Health justifies the need for additional information, including how the delay is in the interest of the enrollee, or if the participant requests an extension.

The reconsideration procedure applies to all benefits offered in Medicare Advantages' benefit packages, including mandatory supplemental benefits, and optional additional benefits.

If a participant requests reconsideration, a decision is made by the Medicare Advantage health plan based on a review of the initial determination and any newly available information. If Medicare Advantage health plan recommends a partial or complete affirmation of Cigna Behavioral Health's initial organization determination, the entire case file is forwarded to the Center for Health Dispute Resolution (CHDR), a CMS contractor. If the Medicare Advantage health plan's decision is partially or fully upheld by CHDR, the participant may have their appeal reviewed by an Administrative Law Judge, if the claim/service that is the object of the appeal is at least $100. If the Administrative Law Judge fully or partially upholds the Medicare Advantage health plan's decision, the participant may request a review by the Medicare Appeals Council of the Social Security Office. If the Medicare Appeals Council denies the request for review, or if it makes a decision which was the final decision of the Secretary, and the amount in controversy is $1,050 or more, a civil action may be filed in a District Court of the United States.

Practitioner Appeals on Behalf of Participants

Practitioners may appeal on behalf of Medicare participants. CMS requires that practitioners be an enrollee's 'authorized representative' in order for the practitioner to request an appeal on the enrollee's behalf. An 'authorized representative' is an individual who receives written authorization by an enrollee to act on his or her behalf in obtaining an organization determination, or in dealing with any level of the appeal process.

Non-participating practitioners may appeal on their own behalf and not as an authorized representative. If the non-participating practitioner appeals, he/she must complete and sign the waiver of liability payment form. The health plan coordinator will work with the practitioner to complete this form.

Appeal of Hospital Inpatient Care Denial (NODMAR)

According to federal law, the participant's discharge date must be determined solely by medical needs and not by any method of payment. Participants have the right to be fully informed about decisions affecting their coverage and payment for their hospital stay and for any post-hospital services.

Participants have the right to request an immediate review by a Quality Improvement Organization (QIO) prior to being discharged from hospital care, if the participant disagrees with the attending physician's decision to discharge. Cigna Behavioral Health will issue a Notice of Discharge and Medicare Appeal Rights (NODMAR) to the participant through the contracted facility staff. The NODMAR notice provides instructions on how to request a QIO review and the applicable time frames.

Grievance Process

Cigna Behavioral Health has established an internal grievance process for receiving and resolving participants' complaints and/or grievances concerning participating practitioners, physicians, or staff. The first step for all grievances is for the participant to speak directly with the practitioner or supervisor in the practitioner's office in which the incident occurred. If the Medicare participant does not feel the matter has been satisfactorily resolved or chooses not to contact the practitioner, he/she may call the Cigna Behavioral Health's Customer Service representative or number on participant's ID card.

When Cigna Behavioral Health cannot resolve a grievance to the participant's satisfaction, it must forward the grievance to the health plan's Medicare Grievance Coordinator within five calendar days from the date the complaint was first received by Cigna Behavioral Health. The Grievance Coordinator will work with the participant to resolve the grievance within thirty calendar days from the date the complaint was first received by Cigna Behavioral Health. If the Medicare participant does not feel the Medicare Grievance Coordinator has satisfactorily resolved the matter, he/she has the right to formal resolution through the health plan's Medicare Grievance Committee. The participant initiates the formal grievance process by making a written request for a hearing before the Medicare Advantage health plan's Grievance Committee. A hearing before the committee will be scheduled within thirty (30) calendar days of the receipt of the written request for a formal grievance. Upon consideration of the facts presented by the participant in writing, the Grievance Committee will render a decision within fourteen calendar days of the Grievance Committee meeting. The participant will be notified in writing of the Grievance Committee's decision, which shall be the final administrative review of the matter

Advance Directives

In accordance with the Patient Self-Determination Act, Medicare managed care plans and participating practitioners are required to ensure that: 1) participants are informed of their rights with respect to advance directives, and 2) documentation regarding execution of Advance Directives is maintained in the medical record.

An advance directive is a written statement completed in advance of serious illness. The statement indicates what kind of medical treatment a participant does or does not want under special serious medical conditions should they become mentally or physically unable to communicate their wishes. The two most common forms of advance directives are Living Will and Durable Power of Attorney.

The Role of the Physician Practitioner

Cigna Behavioral Health requires all practitioners to make a notation in the participant's medical record as to whether or not the participant has completed an Advance Directive. When an Advance Directive exists, a copy should be placed in the medical record. As long as he/she is of sound mind, the participant may complete an Advance Directive form and may revoke it at any time.

Under the law, a participant has the right to refuse medical treatment and to have his/her Advance Directives followed. If a practitioner cannot in good conscience follow those directives, s/he must contact Cigna Behavioral Health's Provider Relations department. Cigna Behavioral Health will then assist the participant in selecting a physician who can comply with these directives.

Neither Cigna Behavioral Health nor its individual practitioners may condition the provision of care or otherwise discriminate against a participant based on whether or not the participant has executed an advance directive.

Access to Services

All services covered by Medicare must be provided in a manner consistent with professionally recognized standards of health care. Cigna Behavioral Health participating practitioners must provide, on a twenty-four hour per day, seven days per week basis, necessary covered services to Medicare participants or arrange for a covering practitioner. A practitioner must ensure that the covering practitioner satisfies Cigna Behavioral Health's

credentialing criteria, and that the covering practitioner will not seek to obtain reimbursement for which the practitioner already receives reimbursement from Cigna Behavioral Health.

Emergency

CMS has established new definitions for emergency and urgently needed services, codifying the concept that an 'emergency medical condition' exists if a 'prudent layperson' could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm to the individual. The new definition of 'emergency services' includes emergency services provided both within and outside of the plan.

Urgently Needed

'Urgently needed services' encompass only services provided outside of the plan's service area (or continuation area, if applicable) except in extraordinary circumstances. Specifically, these regulations allow for coverage of non-emergency services where the services are immediately required because of unforeseen illness, injury or condition, and it is not reasonable given the circumstances to obtain the services through the network of participating practitioners.

Post-Stabilization

The regulations allow for Cigna Behavioral Health to assume financial liability for post-stabilization care.

'Post-stabilization' care means medically necessary, non-emergency services needed to ensure that the enrollee remains stabilized from the time that the treating hospital requests authorization from Cigna Behavioral Health until:

- The enrollee is discharged;
- A Cigna Behavioral Health practitioner arrives and assumes responsibility for the enrollee's care; or
- The treating practitioner and Cigna Behavioral Health agree to another arrangement.

The decision of the examining practitioner treating the individual participant prevails regarding when the participant may be considered stabilized for discharge or transfer.
Cigna Behavioral Health is responsible for the cost of post-stabilization care provided by practitioners outside the plan when Cigna Behavioral Health does not respond to a preapproval request by the practitioner within one hour after the request was initiated, or if Cigna Behavioral Health could not be contacted for preapproval. Cigna Behavioral Health's liability will extend until the hospital is contacted to arrange for discharge or transfer of the participant.

Plan Benefits

Medicare Advantage Medicare participants receive the full range of Medicare services plus additional benefits that are not covered by Medicare; for example, prescription drugs and routine care may be included. Please check with Cigna Behavioral Health's care center for additional benefits applicable to individual participants.

Participants can access mental health and substance abuse services directly through Cigna Behavioral Health. They do not require a referral from their Primary Care Physician.

Many Medicare Advantage organizations such as Cigna HealthCare offer extra benefit riders or special additional benefits for employer sponsored retiree groups. Since it is extremely important that each participant receive all the benefits and supplies he/she is entitled to, we encourage practitioners to get acquainted with the various Cigna benefit options in your area and check specific coverage details on every participant.

The following are the standard benefits that must be offered all Medicare Advantage participants.
Outpatient Mental Health Services:

- Mental health follow-up diagnostic services.
- Mental health therapeutic office services.
- Mental health hospital day treatment.
- Alcohol and substance abuse day treatment program.

Inpatient Mental Health Services:

- Lifetime maximum of one hundred ninety days of care provided in a Medicare-approved psychiatric hospital or licensed psychiatric ward for mental illness and substance abuse combined.

Participant Billing

Practitioners must hold Medicare Advantage participants harmless for payment of fees that are the legal obligation of the Medicare Advantage organization to fulfill. Such provision will apply, but not be limited to insolvency of the Medicare Advantage organization, contract breach, and practitioner billing. Under no circumstances is a Medicare Advantage participant to be balance billed for care, service, or supplies. If the practitioner uses an automatic billing system, bills must clearly state that they have been filed with the insurer and that the participant is not liable for payment other than applicable copayments.

Should a Medicare Advantage participant elect to have care or service provided that is not a covered benefit or which have been determined prior to providing the service to not be medically necessary or any other reason, the practitioner must have written agreement of financial responsibility from the participant including the exact dollar amount. This agreement must be signed in advance of service delivery and be added to the permanent medical record of the participant. It is the practitioner's responsibility, not the participant's, to determine coverage parameters in advance of providing the medical service.

Practitioner Termination/Status Change Notification

Cigna Behavioral Health and its participating practitioners must accept all Medicare Advantage participants who select them unless the health plan is notified in advance that the practitioner cannot accept additional participants. Practitioners must give 60 days notice of termination and thirty days notice of significant access changes (i.e., vacations).

The practitioner shall immediately notify Cigna Behavioral Health of any change in practitioner's licensure and/or certifications that are required under federal, state, or local laws for the provision of Covered Services to Medicare participants, or change in practitioner's hospital privileges, whether at a Cigna Behavioral Health participating facility or non-participating facility.

In the event that Cigna Behavioral Health has cause to terminate the agreement of a participating practitioner that provides services to Medicare participants, Cigna Behavioral Health will issue the practitioner a written notice. The notice will include, to the extent that it is relevant to the decision: (1) the reason for termination, (2) the standards and the profiling data used to evaluate the practitioner, (3) the numbers and mix of practitioner required in its network, and (4) the terminated practitioner's right to appeal the action and the process and timing for requesting a hearing.

If either party terminates a participating practitioner's agreement, Cigna Behavioral Health will notify all Medicare participants that are seen on a regular basis by that practitioner. The written notification will be made to affected participants within fifteen working days of receipt or issuance of a notice of termination.

Excluded practitioners

In accordance with 42 CFR 422.752, Cigna Behavioral Health and its downstream practitioner are barred from employing or contracting with individuals who are excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act, or with an entity that employs or contracts with such individuals for the provision of any of the following:

- Health care
- Utilization review
- Medical social work
- Administrative services

Individuals or entities found to be in violation of this regulation may be subject to sanctions and civil money penalties including, but not limited to, fines ranging from $10,000 to $100,000, suspension of enrollment of Medicare beneficiaries, and suspension of payments.

Insurance

Practitioners must obtain comprehensive general liability, professional liability, workers' compensation and other insurance, in amounts determined by Cigna Behavioral Health, based on the practitioner's mode of practice/specialty, to insure against any claim(s) for damages resulting from personal injuries or death related to the provision of services pursuant to the Participating Provider Agreement.

If the professional liability insurance is written on a 'claims made' basis, practitioner agrees that:

(1) if the Participating Provider Agreement is terminated, the practitioner will continue this insurance with the same or greater policy limits for a period of at least six years following termination; or (2) if this 'claims made' policy is terminated for whatever reason, practitioner will procure and maintain 'tail' coverage professional liability insurance at the same or greater policy limits as the primary policy for a period of not less than six years following the termination of the preceding policy.

Practitioner will submit evidence of this insurance to Cigna Behavioral Health in a timely manner. Practitioner will notify Cigna Behavioral Health at least 30 days prior to the expiration, termination, or material change in the coverages listed on the practitioner's application. This provision shall survive the termination of the Cigna Behavioral Health Participating Provider Agreement.

Compensation

1. Practitioners are to accept reimbursement from Cigna Behavioral Health in the amount set forth in and in accordance with the Cigna Behavioral Health Participating Provider Agreement, its Exhibit(s) and the terms of the Medicare Participant's Plan, as full payment for Covered Services. The rates shall apply to all Covered Services. Cigna Behavioral Health shall notify practitioner of the Copayment, Deductible, or Coinsurance, if any, which shall be charged to the Medicare Participant pursuant to the Medicare Participant's coverage under his/her Plan.

2. Practitioners are to submit an itemized bill for Covered Services personally rendered, on forms acceptable to Cigna Behavioral Health within sixty days of the Service date. Practitioner shall supply any additional information reasonably requested by Cigna Behavioral Health to verify that practitioner rendered Covered Services and the usual charges for such services. Cigna Behavioral Health may deny payment for claims not submitted within sixty days from the Service date, unless practitioner can demonstrate to Cigna Behavioral Health's satisfaction that there is good cause for such delay. The practitioner will not be in default if coordination of benefits precludes a timely submission of a bill. The practitioner will submit the bill as soon as reasonably possible after coordination of benefits activities. Payment may be denied for services that are not Covered Services, not Medically Necessary, or if the Medicare Participant was not eligible for coverage under the Plan.

Physician Incentive Plan (PIP)

PIP regulations require disclosure of financial relationships between Cigna Behavioral Health and practitioner who could put practitioner at significant risk. CMS seeks to ensure that they are aware of financial incentives for practitioners to withhold referrals for medical care. There is an elaborate process established to calculate 'significant financial risk'. The process requires consideration of numbers of enrollees involved and whether the financial arrangements involve agreements such as capitation, withholds, or bonuses. Physician practitioners are required to secure Cigna Behavioral Health's prior approval of any practitioner incentive arrangements relating to Medicare agreement participants.

1. Prior to the execution of the Cigna Behavioral Health Participating Provider Agreement and throughout the term of the Agreement, practitioner shall submit to Cigna Behavioral Health and secure Cigna Behavioral Health's prior approval of any practitioner incentive arrangements relating to Medicare Agreement Participants and the Covered Services rendered. Cigna Behavioral Health has the right to disclose such arrangements if required to do so by applicable laws and regulations. Practitioner shall maintain at their sole expense any stop-loss coverage required to be maintained by applicable law in connection with any such practitioner incentive arrangements and shall provide evidence of such coverage upon request.

2. Prior to the execution of the Cigna Behavioral Health Participating Provider Agreement, practitioners shall secure approval from Cigna Behavioral Health with regard to the percentage of the total Covered Services under the Agreement which may be 'referral services' as that term is defined under applicable laws and regulations.

Practitioner shall not change the percentage of referral services without Cigna Behavioral Health's prior written approval.

Obligations Under Federal Funding

Payments received in connection with services rendered to Medicare Advantage participants are, in whole or in part, from Federal funds. Recipients of such payments are subject to certain laws that are applicable to individuals and entities receiving Federal funds, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other applicable laws and rules. Also, in order to comply with the Centers for Medicare and Medicaid Services (CMS) requirements for Medicare Advantage organizations, Cigna Behavioral Health and Medicare Advantage organizations must follow federal regulations identified in the Balanced Budget Act of l997 and the Medicare Modernization Act of 2003. All written arrangement between a practitioner and downstream entities must comply with applicable Medicare laws and regulations. All practitioners must agree to comply with the Medicare Advantage organization's policies and procedures.

EAP

The Employee Assistance Professionals Association's (EAPA) definition of an EAP is:
". . . a workplace-based program designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns including, but not limited to: alcohol, drug, legal, emotional, stress, and other personal concerns which may adversely affect employee job performance."

Key objectives of EAP programs are to:

- Support employers through assistance for employees to constructively manage personal problems, which may have a negative impact on job performance.
- Work closely with employer's health care benefit programs and local community resources.
- Accurately and quickly match client needs with appropriate resource assistance.

Cigna Behavioral Health's EAP services are promoted as a resource to assist employers, employees and their household members in identifying and resolving issues of daily life. The program offers participants a work life service with lifecycle information, consultation and referral as well as the opportunity for short-term counseling with professionals skilled in the assessment and treatment of a wide range of problems. The results for the sponsoring organization can be significant:

- higher employee productivity,
- prevention of potentially costly problems in the workplace,
- the comfort of professional assistance in response to a critical incident
- the retention of good employees who appreciate their organizations efforts to maintain a healthier workforce.

A "participant" is: ". . . the eligible employee and his/her household members."

Cigna Behavioral Health's EAP Models

Assessment and Referral (A&R)

Assessment and Referral entails one to three face-to-face sessions focusing on participant problem identification and resolution or referral to appropriate resources to complete problem resolution.

Short-Term Counseling (STC)

Short-Term Counseling focuses on the resolution of the presenting problem within the EAP. The most common for Cigna Behavioral Health's short-term therapy model are five to eight session programs.

Participation in our EAP/Short-Term Counseling (STC) plans has been increasing. This product includes more than three sessions and sometimes up to twelve. The goal of this product is to try and achieve problem resolution within the EAP STC. If, after assessing, you determine that is not an appropriate goal, you should refer on to the behavioral health benefit. Again, you must contact us when the EAP STC assessment is complete.

Stand-Alone EAP Services

Cigna Behavioral Health is the participant's practitioner for only EAP services. Behavioral health care services are not covered through Cigna Behavioral Health. Stand-alone EAPs may be either A&R or STC.

Integrated EAP Services

Cigna Behavioral Health is the participant's practitioner of both EAP and Behavioral Health Care services. Integrated EAP models may also be either A&R or STC.

If you are participating with Cigna Behavioral Health to see EAP participants, you are well aware of our face-to-face counseling program. The majority of our EAP customers have a one to three EAP model: Assess and Refer. This model gives you up to three sessions to formulate a participant's situation, communicate those findings to the participant, and if ongoing care is necessary, make a referral into the participant's behavioral health benefit. There are two important things to remember:

- Where clinically appropriate, you may refer the participant to yourself for continuing care; and
- You must contact us to close the EAP case once the assessment is complete.

Exclusions

The Cigna Behavioral Health EAP benefit excludes coverage for:

- Psychiatric Evaluations
- Psychological Testing
- Court-Ordered Treatment
- Workers' Compensation/Disability Management
- Medication Management
- Fitness for Duty/Return to Work Determinations

Non-clinical services not covered by the EAP include:

- Employment Law

Special Note: Coverage for Employment Law is excluded due to the dual nature of the EAP client—the individual employee (family participant) and the employer who sponsors the program. Any legal information or advice given by a practitioner to an individual client concerning employment law can have potentially detrimental consequences for the employer client. To avoid this conflict of interest, Employment Law services are excluded from the program.
In the course of providing EAP services, practitioners shall refrain from discussing legal recourse as a potential action in resolving workplace concerns or disputes. Employees with concerns about workplace practices should be referred to their Human Resources department for further assistance.
Examples of excluded employment law questions or concerns are:

- Workplace safety, accidents, injuries, or illnesses;
- Coworker liability (including workplace assaults or threats);
- Employee benefits issues/disputes or disputes concerning the agents of company-sponsored benefits or services;
- Pension rights, employment termination, retirement questions or disputes;
- Employer-based civil rights violations (including workplace sexual harassment allegations); and
- All other alleged employer liability issues.

Eligibility

Unlike behavioral health care services, in all but a very few cases eligibility for EAP services is not verified. Employees, their dependents and their household members are eligible for EAP services. Some customers extend EAP services to

retired employees. There is no limit to the frequency with which eligible individuals can access EAP services for new problems or concerns.

Types of Referrals

Participants may contact the EAP as soon as they feel consultative assistance may be helpful. To prevent possible adverse impact on job performance, employees with personal concerns are encouraged to contact the EAP. Participation in the EAP is confidential within the limits of the law. Participants may access the EAP in one of three ways: self-referral, management referral or continuation of employment referral.

Self-Referral

An EAP Self-Referral occurs when the participant contacts the EAP directly and voluntarily seeks assistance for a personal concern. The employer is given no information regarding the individual participant's contact.

Management Referral

An EAP Management Referral involves circumstances where the employee has had job performance issues that have generated the referral by a manager or human resources contact. A Management Referral consists of a voluntary assessment through the EAP wherein the employee is asked, but not required, to consent to the referral and sign a 'Release of Confidential Information' (ROI) (see Appendix E) between Cigna Behavioral Health and the referring manager. The ROI form will allow the referring party to be informed of the employee's compliance with EAP attendance and recommendations. Participation in the EAP will not jeopardize the employee's job security, promotional opportunities, etc. Conversely, participation in the EAP will not protect the employee from disciplinary action that may result from substandard job performance, conduct infractions or a violation of company policy. EAP practitioners working with Management Referral Cases are expected to work with an assigned Cigna Behavioral Health EAP Consultant who maintains communication with the referring manager. EAP practitioners are not expected to contact the referring manager and should direct inquiries to the Cigna Behavioral Health EAP Consultant.

Management Referral *Practitioner Procedures*

- Meet with the Employee:
    - Complete a comprehensive assessment.
    - Formulate a plan to address the workplace performance issues and any areas that may be contributing to the problem. Keep in mind that you have two 'clients' with an EAP Management referral: the employee and the employer.
    - Inform the employee of your specific recommendations and let the employee know that those recommendations will be reported back to the employer. No clinical or diagnostic information will be given to the employer.
    - If a referral is needed, provide the employee with the contact information for the referral resource. Obtain permission from the employee to communicate with the referral resource. Follow up with the referral resource to verify initial compliance.
- Contact the Cigna Behavioral Health EA Consultant with the initial update:

  EAP dates of Service.

    - Presenting Problem.
    - Diagnostic Impressions (CD, MH, medications, risk of harm).
    - How are the workplace concerns being addressed?
    - Is the employee compliant with EAP process?
    - Date of next EAP appointment.
    - Recommendations or referral? Please provide a name and contact number for the referral resource.

Do not communicate directly with the employer or complete any paperwork for the employee regarding return to work, disability, fitness for duty, etc.

- Update the EA Consultant regarding the employee's compliance:
    - Dates of subsequent EAP appointments.
    - The employee's progress/compliance with the EAP process.
    - If a referral was made, verification that the employee began attending the recommended treatment.
    - Date that the EAP case was closed and any recommendations for continued treatment.

The EA Consultant obtains a signed release via the referring manager and provides the following information:

- Dates of EAP appointments attended or not attended.
- Date of next EAP appointment.
- Any recommendations for services beyond the EAP. The information given to the employer is limited to the level of care, type of referral resource (inpatient, outpatient, etc.), and the name of the treating practitioner and/or facility.
- The employee's demonstrated compliance with the initial recommendations.

Continuation of Employment Referral

An EAP Continuation of Employment Referral is a referral by a manager or human resources representative that has been offered in lieu of termination. Common precipitants to continuation of employment referrals include, but are not limited to, substance abuse policy violations. In this situation, the employee is required to sign an ROI form (see Appendix E) that allows communication between Cigna Behavioral Health and the referring party. In some cases, the EAP practitioner may be asked to obtain the ROI.

The ROI form will allow management to be informed of compliance with EAP attendance and recommendations. EAP practitioners who receive Continuation of Employment Referrals are expected to work with a Cigna Behavioral Health EAP Consultant who maintains communication with the referring party. It is extremely important that practitioners respond to the inquiries and requests for updates from the EAP Consultant managing the compliance reporting back to the referring manager or company contact, as these cases involve job jeopardy for the participant. Additionally, the Cigna Behavioral Health EAP Consultant will work collaboratively with the EAP practitioner in regard to cases where their provision of Substance Abuse Professional (SAP) services is requested.

Prepaid Benefit

As Cigna Behavioral Health EAP services are free to eligible participants, there are no out-of-pocket expenses or copayments collected by EAP practitioners. If a treatment referral is needed beyond EAP services, the employee or household member will receive expense reimbursement in accordance with his/her health plan coverage. Employees should review such coverage with the EAP practitioner prior to a referral in order to determine what expenses will be covered by his/her medical plan. EAP practitioner questions about coverage should be directed to Cigna Behavioral Health Care Management staff.

Barrier-Free Access

Eligible participants have access to Cigna Behavioral Health's EAP services twenty four hours a day, three hundred sixty-five days a year through a toll-free telephone number. Licensed clinical professionals in our Care Center address emergency or crisis situations immediately. During routine calls, EAP participants speak with Cigna Behavioral Health Personal Advocates who will review their EAP benefit, discuss their personal concerns and identify local EAP practitioners for referral purposes.

Only in the event of a management/mandatory referral will a Cigna Behavioral Health staff member give the EAP practitioner advanced notification of the EAP participant's name, the employer group, presenting problem, type of EAP benefit and type of referral. Unlike health benefits through Cigna, EAP benefits continue to require preauthorization. All EAP claims should be billed using CPT code 99404.

Self-referring participants may choose to register for EAP services, select a practitioner and receive an authorization for services online at www.cignabehavioral.com. In this case, both the practitioner and participant will receive a letter confirming the approved service.

Cigna Behavioral Health's appointment access standard for routine EAP cases is two business days. If the EAP practitioner cannot offer an appointment within this timeframe (when it is requested), the participant should be directed back to the Cigna Behavioral Health referral source.

If a participant schedules an appointment and fails to keep it, the practitioner should contact the participant to discuss his/her intentions. The practitioner is expected to report any participant concerns or complaints regarding satisfaction with EAP services to Cigna Behavioral Health.

Assessment and Evaluation

During the assessment, the EAP practitioner identifies the nature of the problem and a possible plan of action. Family, significant others and friends may be included in this process, as appropriate. The EAP assessment routinely focuses on the individual's level of functioning in the workplace, presence of any contributing stressors as well as the need to develop additional coping skills that might enhance job performance and occupational satisfaction. EAP practitioners use information from the assessment to:

- Help the participant clarify the nature of the presenting problem.
- Identify underlying and/or collateral issues, including non-clinical contributing factors (e.g., legal, financial, or child/eldercare needs).
- Evaluate the level of problem/symptom severity.
- In collaboration with the participant, create an appropriate action plan.

Cigna Behavioral Health encourages the EAP practitioner to work with the EAP participant to resolve his/her presenting problems within the available EAP visits whenever possible.
All EAP participants must receive a Statement of Understanding (see Appendix E) at the beginning of the initial session. Should the participant refuse to sign the Statement of Understanding, please so note on the form and place it in the participant's file.

If the EAP participant reveals legally sensitive information regarding the workplace (e.g., sexual harassment, discrimination issues, etc.) and/or requests the practitioner to contact the workplace, please notify a Cigna Behavioral Health EAP Consultant prior to taking any action. Under no circumstances should the EAP practitioner suggest that employee consult with or retain an attorney for the purpose of assessing the potential for legal action against the employer.

EAP practitioners are encouraged to remain aware that, in EAP work, there is a 'dual client' relationship. The practitioner has both the organization/employer and the participant seeking services as the client. In instances where a concern about conflict of interest arises in this dual client relationship, the practitioner is urged to utilize our EAP Consultants as a resource.

Disposition

In order to ensure participants receive appropriate services and value from their EAP program, Cigna Behavioral Health encourages EAP practitioners to work with the participant to resolve the presenting problems within the context of the EAP. If the participant has only EAP benefits with Cigna Behavioral Health, the EAP practitioner will coordinate referrals for ongoing care directly with the participant either to their behavioral health benefits or appropriate community resources.

If Cigna Behavioral Health manages the EAP participant's behavioral care benefits, referrals must be coordinated with a Cigna Behavioral Health Care Manager. The EAP practitioner may request to continue providing care if/when the following criteria are met:

- Cigna Behavioral Health provides both the EAP and behavioral care benefits for the participant;
- Continuation is clinically the most efficacious course of treatment;
- It is the participant's request; and

- At least two other individual practitioner options are communicated.

When Cigna Behavioral Health authorizes continuation of care with the EAP practitioner, the practitioner should obtain the participant's signature on the Waiver of Financial Responsibility form (see Appendix E) and place the form in the participant's file.

If Cigna Behavioral Health does not manage the participant's mental health and substance abuse benefits, or no benefits are available for the participant, the EAP practitioner is expected to facilitate an appropriate transition to alternate resources. This may include referrals to community-based treatment programs or counseling agencies and/or interface with other HMOs, etc. The EAP practitioner is expected to secure an appropriate Release of Information and contact the treatment practitioner or community resource to alert them to the referral and confirm that the appropriate services can be provided.

Information, resources and referrals are also available through the Cigna Behavioral Health EAP for legal, child and elder care, pet care, HealthyRewards® and other work-life needs. The EAP practitioner should direct the participant to call the Cigna Behavioral Health EAP for these services. In addition, EAP practitioners are expected to maintain knowledge of community-based support groups and resources that may offer additional services (e.g., financial concerns, debt management, personal budgeting) and assist in the transition to these resources.

Follow-Up and Case Closure

Approximately forty-five days after a referral is made, a Cigna Behavioral Health Personal Advocate contacts the participant, with prior permission, to assess whether his/her needs were met through the services that were provided. Given this telephonic contact now includes a formal participant satisfaction survey, *it is no longer necessary for the practitioner to distribute the paper survey (EAP Participant Survey, form #00030) at the close of the EAP episode.*

To ascertain the disposition of a case, EAP practitioners are required to contact the participant ten to fourteen days after the conclusion of the EAP episode of care to ensure that the participant has success-fully connected with treatment and/or community resources for ongoing care or to confirm that no further assistance is needed. The information on case disposition must be reported back to a Cigna Behavioral Health staff participant in order to close the EAP episode of care. The information required is:

- Dates of service.
- Date of follow-up with the participant.
- Diagnosis.
- Risk assessment.
- Medication status.
- Current chemical dependency issues.
- Confirmation that the Statement of Understanding was signed.
- Recommendation for additional care/resources.
- Name(s) of practitioner(s) to whom the participant was referred.
- Confirmation that the participant was contacted post-EAP and has either successfully engaged in ongoing treatment or that no additional resources are necessary.

Claim Payment Process

All EAP claims should be submitted with a CPT code of 99404. EAP claims submitted without the required CPT code will be denied.

Confidentiality

Cigna Behavioral Health's EAP success and credibility hinge on the confidence that the EAP respects the individual's right to privacy and will protect the information they disclose within the parameters of the law. The EAP will maintain the confidentiality of participants and fully disclose conditions that limit confidentiality. EAP practitioners will not share information regarding involvement in the program without the prior knowledge and written permission of the participant, except as required bylaw. Every effort is made to maintain strict confidentiality with self-referrals, management referrals, and continuation of employment referrals.

Management Consultation and Education

The Cigna Behavioral Health EAP provides a number of consultative and educational tools to help managers recognize and address multiple workplace issues including potential or existing substance abuse problems. Education, training, and reference guides are available to assist supervisors and human resource managers with problem recognition, intervention, EAP referral, follow-up and reintegration of employees into the workplace.

Cigna Behavioral Health EAP services provide Management Consultation by Certified EAP Professionals, on a per case basis, to support supervisors and human resource managers in developing immediate strategies to deal with performance issues, workplace behavior that may be indicative of potential alcohol and/or other drug problems, violence at work and at home, workplace crises, critical incidents and other sensitive situations. Management Consultation is available twenty-four hours a day, three hundred sixty-five days a year.

EAP practitioners are expected to collaborate with a Cigna Behavioral Health EAP Consultant in servicing challenging Management Referral, Continuation of Employment Referral and Workplace Trauma Incidents.

Promotion

Cigna Behavioral Health believes clear communication about the EAP benefit, at the time it is implemented, as well as frequent reminders about the EAP, enhances the visibility of the program and encourages utilization of available services. EAP communication materials include brochures, wallet cards, videos, and guides for managers, newsletter articles, as well as quarterly awareness brochures and posters on wellness, prevention, and personal growth. Cigna Behavioral Health also has an extensive library of Wellness Seminars that are available to EAP customers and delivered on-site at employer locations by EAP practitioners. In addition, employee orientation sessions, supervisory training, wellness seminars and health/benefit fairs provide an effective means to enhance the visibility of Cigna Behavioral Health's EAP program. Cigna Behavioral Health also provides timely access to EAP information through *Intranet* and *Extranet* sites. These resources provide additional avenues to make the availability of EAP prevention, early intervention, consultation and work/life services known to the organization and its participants.

Practitioner Roles

As a participating Cigna Behavioral Health EAP practitioner, communication is critical to facilitate the effective resolution of participant issues. Our collaborative vision of program services involves the recognition and balancing of both the needs of the employee and employer. A Cigna Behavioral Health EAP Consultant will facilitate communication, when indicated, with the EAP participant's employer.
Employers who request information from the EAP provider should be directed to the Cigna Behavioral Health Employee Assistance Consultant. Direct communication between the EAP practitioner and the participant's employer must be reviewed and approved in advance by Cigna Behavioral Health.

EAP Specialty Services

Cigna Behavioral Health's EAP integrates Practitioner Specialty Skills in the provision of Critical Incident Assistance, Substance Abuse Professional Services, Employee Education & Wellness Seminars and Management Training. Cigna Behavioral Health's Provider Relations department facilitates the recruitment, orientation and privileging of EAP practitioners in these EAP specialty service areas.

Note: In order to have the Critical Incident Specialty added to your profile, you must sign an attested specialty form confirming that you:

- Have received formal training in Critical Incident Response
- Have delivered a minimum of 4 CIR services in the past 2 years, and
- Agree to make changes to your schedule to accommodate CIR requests within **2-12 hours**.

International EAP Services

In order to minimize the risks that could interfere with the success of an overseas assignment, Cigna Behavioral Health offers *Pre-deployment* assessments and support for employees and their families.
Additionally, *Repatriation* assessments and support after a completed overseas assignment are available to help facilitate reculturation upon returning to the United States.

Quality Management

Cigna Behavioral Health's Quality Management Program supports our goal of continuous improvement in the quality of care and services delivered to participants.

Cigna Behavioral Health is accredited by the National Committee for Quality Assurance (NCQA) as a Managed Behavioral Health Organization (MBHO).

Additionally, the Quality Management Program is designed to fulfill Managed Care Organization (MCO) standards and to support health plan customers in their accreditation through the NCQA.

Cigna Behavioral Health values the input and involvement of our practitioners in our Quality Management Program, and we communicate program results annually in our national practitioner and provider newsletter. If you would like to receive more information, become more involved, or offer feedback and suggestions concerning Cigna Behavioral Health's Quality Management Program, please contact us at 800.926.2273.

Creating Opportunities for Quality Improvement

Through Cigna Behavioral Health's Quality Management Program, data about many aspects of our operations is reviewed and monitored quarterly or annually to assess performance and create improvements in care and service for participants. Data reviewed and monitored include:

- Practitioner satisfaction surveys
- Participant satisfaction surveys
- Practitioner medical record audits
- Complaint and appeal analysis and trending
- Utilization data
- Compliance with Cigna Behavioral Health's appointment access, practitioner and practitioner geographical availability, and telephone access standards
- HEDIS® (Healthcare Effectiveness Data and Information Set) metrics
- Follow-up after hospitalization. Typically, all discharged participants should be seen within seven working days of discharge

Coordination of Behavioral Health and General Medical Care

It is the policy of Cigna Behavioral Health that behavioral health services must be closely coordinated with general medical care and between behavioral care providers when care is delivered simultaneously by more than one provider, program or facility. To enable the sharing of information between providers as treatment proceeds, Cigna Behavioral Health suggests that providers request a required Release of Information signature from the participant during the treatment process, even if the participant initially declines permission for communication between professionals. For the coordination of medical and behavioral care especially, this policy reflects Cigna Behavioral Health's understanding of the complex interrelationship between emotional and physical factors, and its appreciation for the fact that psychiatric problems often complicate or present as medical illnesses. Conversely, medical problems may present with psychiatric symptoms.

Appendix G includes a sample release form and a draft letter for structured communication with PCPs. You are welcome to use these tools to support your communication with PCPs.

For each consenting participant in simultaneous medical and behavioral treatment, Cigna Behavioral Health practitioners are expected to:

- Obtain and document the Medical Care Practitioner's/Primary Care Physician's (PCP's) name, address, telephone, and facsimile (if available) numbers.

- Obtain and document a Release of Information, as required by law, to exchange information between you and the Medical Care Practitioner/Primary Care Physician. If the participant refuses to sign a release for communication with the Medical Care Practitioner/Primary Care Physician, the reason for refusal should be documented.
- Exchange appropriate clinical information directly with Primary Care Physicians in an effective and timely manner throughout the treatment regimen. With proper consent, facilities may contact Primary Care Physicians upon admission and discharge. Outpatient practitioners are expected to exchange appropriate clinical information directly with PCPs in an effective and timely manner throughout treatment, and at a minimum, communication should occur:
    - After the initial assessment, to include diagnosis, medication, initial treatment plan, and diagnostic tests recommended or ordered.
    - When a participant is not compliant with treatment recommendations.
    - When a participant's condition is unstable.
    - When there are clinically significant changes in a participant's condition and/or level of care, including but not limited to, inpatient, partial hospitalization, intensive outpatient treatment, comorbid medical and behavioral conditions, new, or substantial medication changes.
    - At the completion of behavioral treatment.
- Document verbal and written communication with PCPs.

Cigna Behavioral Health monitors a healthcare professional's compliance coordinating behavioral care with medical care through medical record reviews and Care Management reviews as part of the recredentialing process and the quality management program.

Treatment Record-Keeping

Cigna Behavioral Health believes well-documented treatment records, whether electronic or paper, facilitate communication, coordination, and continuity of care; and promote the efficiency and effectiveness of treatment. The health practitioner is responsible for maintaining an adequate clinical record for each participant and furnishing Cigna Behavioral Health with clinical data as necessary for utilization review or quality management. Cigna Behavioral Health's record-keeping standards require the participant name and identification number on each page in the record. Treatment record entries should be legible, signed with the clinician's name and credentials, in ink, dated, and maintained in a consistent chronological order within each file. Records should be easily and readily retrievable in a secure environment that protects participant confidentiality.

Treatment Record Review (TRR) standards are based on state mandates, when applicable, and Centers for Medicare & Medicaid Services (CMS) requirements regarding treatment of Medicare participants.

The practitioner's treatment records should include documentation of all contacts regarding the participant. Documentation in the record should include, but is not limited to:

- Key demographic data.
- The presenting problem (reason for visit).
- A full psychological and medical history.
- A mental status evaluation including assessment of suicidal and homicidal ideation.
- ICD-10 diagnosis.
- Treatment plan with measurable goals.
- All diagnostic and treatment services ordered or provided, directly or through referral.
- With participant consent, evidence of coordination of care with the PCPs and other involved clinicians, in addition to other record-keeping requirements outlined in the Behavioral Treatment Record Review Tool (Appendix D).
- Centers for Medicare & Medicaid Services (CMS) requirements on whether:
    - Were Advanced Directives executed?

- Does the Primary Care Provider have a copy of the Advanced Directives?

To support your efforts in documentation, behavioral providers are encouraged to document in the treatment record:

- Your attempts to coordinate care with the client's PCP.
- Discussions in which you encourage clients without a PCP to choose a PCP.

To assess compliance with its medical record standards, the medical record-keeping practices of selected high volume practitioners are audited by Cigna Behavioral Health. As high volume practitioners near recredentialing, participants seen by them in the prior twelve (12) months are identified. A letter is sent to selected practitioners professionals, soliciting blinded copies of three (3) clinical records. Audit results are used to give practitioners feedback (particularly when results are below the 80% performance goal) and to drive organizational quality improvement. Cigna Behavioral Health has also found that effective treatment record documentation supports treatment outcomes through improved treatment planning, the monitoring of participant progress towards goals, and improved communication in the case management process.

Quality clinical record-keeping may also reduce risk management difficulties for practitioners by providing a record of the treatment progress along with documentation of informed consent, participant's understanding of their rights and responsibilities and participant's understanding of the treatment plan. Please see Appendix D, which is a sample 'Informed Consent Form' you are welcome to use.

In states where there are laws regulating the record-keeping process, these laws shall prevail if greater than Cigna Behavioral Health's minimum standards; if not, Cigna Behavioral Health standards shall apply.

Participant Rights and Responsibilities

Cigna Behavioral Health supports informing patients of their rights and responsibilities related to the provision of care and service. As a Cigna Behavioral Health practitioner, you should:

- Facilitate the participant's awareness of the Cigna Behavioral Health Participant Rights and Responsibilities statement at their first appointment. *This can be accomplished by providing a copy to the participant or display of the document. The information in Appendix C can be copied for this purpose.*
- Offer to help the participant get more information about any of the items in the statement.
- Notify the participant how to access services, including service outside of normal business hours.
- Discuss the services available to the participant and possible charges for those services.

Please note there are states with specific participant notification requirements applicable to mental health and/or substance abuse services, and/or to HIV status. The Cigna Behavioral Health Participant Rights and Responsibilities do not necessarily meet all state-specific requirements. State laws vary on participant, access to records, and duty to warn. Therefore, an addendum with required language must be attached to this document to comply with your state specific regulations. Please consult your legal advisor for guidance.

EAP participants should be provided an EAP Statement of Understanding see Appendix E.

Cigna Behavioral Health is committed to maintaining and protecting the confidentiality of patient's personal and sensitive information. To better understand our handling of personal health information, refer to the statement located in Appendix C.

Improving Participant Safety

The Institute of Medicine emphasized the safety of health care in the public spotlight by publication of their report, "*To Err is Human: Building a Safer Health System.*" As a result, safety catapulted to a national health care issue. Every health care practitioner should be evaluating:

- What is my role in preventing potential errors or safety risks?
- What barriers exist to improving participant safety?
- What strategies can be implemented in my practice to reduce errors or improve safety?

While there are many steps needed to reduce error in America's complex health care system, a few steps practitioners can consider include:

- With approved consent, communicate and coordinate care with other behavioral health, primary care, or other health care practitioners who are involved in the participant's care.
- Gather information on all prescription and over-the-counter medications and dietary supplements the participant is on.
- Inquire about any known allergies or adverse medication reactions.
- Educate the participant on how and when to take medication and how to manage possible side effects.
- Evaluate how computerized records and other technology may contribute to improved safety.

Through the Quality Management Program, Cigna Behavioral Health evaluates data on various measures to identify opportunities for improving safety for our participants.

Health Promotion/Preventive Health Services

Cigna Behavioral Health encourages participating practitioners to educate participants about their diagnosis along with treatment information and suitable health promotion strategies. This may also include providing literature, suggesting books, or informing the participant of other educational resources and self-help groups. As appropriate, the practitioner should recommend the use of preventive strategies that may include relapse prevention, stress management, wellness programs and lifestyle changes. In addition, be sure to document your efforts in your medical record.

Cigna Behavioral Health offers a Preventive Health Program for Attention-Deficit/Hyperactivity Disorder (ADHD) as well as consumer oriented educational materials on a variety of topics.

The intent of our Attention-Deficit/Hyperactivity Disorder (ADHD) program is to educate and empower caregivers, to reduce the impact of problems commonly associated with the disorder and to encourage early detection of ADHD in siblings.

Automated rules in our claims processing system identify each new case of ADHD. Educational information and tools are mailed to parents and guardians to improve their understanding of, and their ability to manage their child's condition and to encourage coordination and consistency of response across medical, behavioral, educational, family, and other social settings.

Initial and annual screening for depression, stress, and anxiety is now routine within Cigna HealthCare's Medical Disease Management Programs, encouraging the identification and treatment of behavioral health disorders that may occur as a coexisting condition with a medical disease. Those who screen positive are provided intensive care management and ongoing standardized protocols for assessment and intervention are applied until the behavioral health condition remits. Where consent is provided, additional materials and support are made available to their medical practitioner or a referral for treatment with a qualified behavioral health practitioner can be arranged.

See Resources for the latest information on these services or contact us at 800.926.2273

Educational Opportunities for Practitioners

You are encouraged to participate in educational programs focusing on clinical practice issues pertinent to service delivery systems.

Medical Necessity Determinations

Cigna Behavioral Health uses a suite of existing evidence-based criteria to support your clinical judgment and decision-making processes. They are compliant with state and federal regulations, including parity, and align with and reference various professional organizations.

For more information about our guidelines, visit the Coverage Policies page of this website and see *Supporting Behavioral Websites*.

Clinical Practice Guidelines

Cigna Behavioral Health has adopted Clinical Practice Guidelines from professional societies and other recognized sources such as the American Psychiatric Association, the American Academy of Pediatrics, or the National Institute of Alcohol Abuse and Alcoholism. Our Care Management staff use these in their work with practitioners to guide decisions about the appropriate type of treatment for common behavioral disorders. The conclusions expressed within these guidelines are based on scientific, evidence-based research. A full list of guidelines currently approved for use and instructions on where the full-text source documents can be obtained through a link on the Resources > Clinical Practice Tools > Clinical Practice Guidelines.

Through the Quality Management Program, Cigna Behavioral Health monitors whether treatment is consistent with selected guidelines that Cigna Behavioral Health Guidelines have adopted. Feedback, suggestions, and input regarding Clinical Practice Guidelines are always welcome and can be provided to Cigna Behavioral Health by contacting a Provider Relations representative at the Cigna Behavioral Health Operating Unit with which you generally work, or by calling Cigna Behavioral Health at 800.926.2273.

Clinical Screening Tools and Treatment Support Toolkits

Cigna Behavioral Health has assembled a number of validated screening and assessment tools and, where necessary, obtained permissions from copyright holders for distribution to our network for use. These can be found at: Clinical Screening Tools.

Additionally, patient and provider toolkits, containing educational and treatment support tools, are available for download and use at: Primary Physician Tool.

Integration with Chronic Condition/Disease Management

Cigna's chronic condition programs (Your Health First ^{SM}) are supported by Cigna Behavioral Health via an integrated approach to help program participants manage chronic health conditions. Your Health First addresses the health of the whole person rather than focusing on a single disease that triggers program participation.

Supported by evidence-based medical guidelines and influential behavioral techniques, the integrated multidisciplinary approach helps participants fully manage their personal health, including adherence to medications, understanding and managing risk factors, maintaining up-to-date screenings and more.

For details regarding Cigna's chronic condition programs, including practitioner rights and responsibilities, see Chronic Condition Management section of the Medical Resources found on CignaforHCP.com, or contact us at 855.246.1873.

Contact Information (Appendix A)

Provider Services Department

800.926.2273

Regional Care Centers

National Care Center
11095 Viking Drive, Suite 500, Eden Prairie, MN 55344
800.554.6931

Chesapeake Regional Care Center
3601 O'Donnell Street, Baltimore, MD 21224
800.274.7603

Dallas Regional Care Center
1640 N Dallas Pkwy, Plano TX 75093
888.800.8849

Glendale Regional Care Center
450 North Brand Boulevard, Suite 500, Glendale, CA 91203
800.866.6534

California Only Phone Numbers

Care Management 800.879.9823
Customer Service 800.753.0540
Professional Relations 800.866.6534

Claims Information (Appendix B)

Document Title	Document Type	Document Size
HCFA/CMS 1500	Online Resource	--
UB04	Online Resource	--
Sample EOB	PDF	24kb

Participant Rights and Responsibilities (Appendix C)

Cigna Customers' Rights and Responsibilities Statement

You Have the Right to:

- Receive coverage for the benefits and treatment available under your health benefit plan when you need it and in a way that respects your privacy and dignity.
- Receive the understandable information you need about your health benefit plan including information about services that are covered and not covered and any costs that you will be responsible for paying.
- Obtain understandable information about Cigna's programs and services, including the qualifications of staff that support Cigna wellness and similar programs and any contractual relationships related to such programs.
- Have access to current information on in-network doctors, health care professionals, hospitals and places you can receive care and information about a particular health care professional's education, training and practice.
- Select a primary care doctor for yourself and each covered member of your family, and change your primary care doctor for any reason. However, many benefit plans do not require that you select a primary care doctor.
- Have your personal identifiable data and medical information kept confidential by Cigna and your health care professional, know who has access to your information, and know the procedures used to ensure security, privacy and confidentiality. Cigna honors the confidentiality of its customers' information and adheres to all federal and state regulations regarding confidentiality and the release of personal health information.
- Participate with your health care professional in health decisions and have your health care professional give you information about your condition and your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language you understand.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.
- Refuse medical or behavioral care. If you refuse care, your health care professional should tell you what might happen. We urge you to discuss your concerns about care with your doctor or other health care professional. Your doctor or health care professional will give you advice, but you will have the final decision.

- Be advised of who is available to assist you with any special Cigna programs or services you may receive and who can assist you with any requests to change or disenroll from programs or services offered by or through Cigna.
- Be heard. Our complaint-handling process is designed to: Hear and act on your complaint or concern about Cigna and/or the quality of care you receive from health care professionals and the various places you receive care in our network; provide a courteous, prompt response; and guide you through our grievance process if you do not agree with our decision. Cigna strives to resolve your complaint on initial contact and in a manner that is consistent with your applicable benefit plan. Language interpretation and TTY services are available for complaint and appeal processes.
- Know and make recommendations regarding our policies that affect your rights and responsibilities. If you have recommendations or concerns, please call Customer Service at the toll-free number on your ID card.

Statement on confidentiality of alcohol and drug abuse records:

Cigna Behavioral Health staff and network practitioners will not identify a participant as involved in alcohol or substance abuse treatment to others outside the treatment program, unless:

- The participant consents in writing; OR
- The disclosure is allowed by court order; OR
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
- The disclosure is made to a primary care physician to coordinate care when required by a health plan and the participant consents verbally or in writing; OR
- The participant commits or threatens to commit a crime at the treatment program or against any person who works for the program; OR
- There is suspected child abuse or neglect or a danger to yourself or others when reporting is permitted or required under state laws to appropriate state or local authorities.

You Have the Responsibility to:

- Review and understand the information you receive about your health benefit plan. Please call Customer Service when you have questions or concerns.
- Understand how to obtain services and supplies that are covered under your plan - including any emergency services needed outside of normal business hours or when you are away from your usual place of residence or work, by using the indicated number on your Cigna ID card or by accessing Cigna on-line resources.
- Show your ID card before you receive care.
- Schedule a new patient appointment with any in-network health care professional; build a comfortable relationship with your health care professional; ask questions about things you don't understand; and follow your health care professional's advice. You should understand that your condition may not improve and may even get worse if you don't follow your health care professional's advice.
- Understand your health condition and work with your health care professional to develop treatment goals that you both agree upon and to follow the treatment plan and instructions.
- Provide honest, complete information to the health care professionals caring for you.
- Know what medicine you take, why, and how to take it.
- Pay all copays, deductibles and coinsurance for which you are responsible, at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the health care professional's office ahead of time if you are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by your plan.
- Voice your opinions, concerns or complaints to Cigna Customer Service and/or your health care professional.

- Notify your plan administrator and treating health care professional as soon as possible about any changes in family size, address, phone number or status with your health benefit plan, or if you decide to disenroll from Cigna's programs and services.

Collection, Use And Disclosure Of Protected Health Information (Appendix C+)

This is not a notice of privacy practices as required by the HIPAA Privacy regulations.** As a third-party administrator and utilization review agent acting on behalf of our health plan customers, Cigna Behavioral Health is committed to maintaining and protecting the confidentiality of participants' personal and sensitive information. This communication outlines how we do so.

Right to Inspect and Copy Confidential Information

Participants may ask to inspect or to obtain a copy of their confidential information that is included in certain records we maintain. Under limited circumstances, we may deny a participant access to a portion of their records. If the participant requests copies, we may charge the participant copying and mailing costs. If the participant's health plan has not delegated administration of this HIPAA Privacy right to Cigna Behavioral Health, we will provide access to the health plan receiving the participant's request.

Right to Request Additional Restrictions

Participants may request restrictions on our use and disclosure of their confidential information for the treatment, payment and health care operations purposes explained in this document. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction.

Right to Amend Records

Participants have the right to ask us to amend their confidential information that is included in our records. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If the participant's practitioner or another person created the information the participant wants to change, the participant should ask that person to amend the information. If the participant's health plan has not delegated administration of this HIPAA Privacy right to Cigna Behavioral Health, we will provide access to the health plan receiving the participant's request, and amend information as the health plan requests and as is appropriate and legally permitted.

Right to Receive an Accounting of Disclosures

Upon request, a participant may obtain an accounting of disclosures we have made of the participant's confidential information. The accounting that we provide will not include disclosures made before April 14, 2003, disclosures made for treatment, payment or health care operations, disclosures made earlier than six years before the date of the participant's request, and certain other disclosures that are accepted by law. If the participant requests an accounting more than once during any 12-month period, we will charge the participant a reasonable fee for each accounting statement after the first one. If the participant's health plan has not delegated administration of this HIPAA Privacy right to Cigna Behavioral Health, we will provide an accounting of any disclosures to the health plan receiving the participant's request.

Right to Receive Confidential Communications

Participants may ask to receive communications of their confidential information from us by alternative means of communication or at an alternative location. While we will consider reasonable requests carefully, we are not required to agree to all requests. Participants who wish to make a request for access, restriction, amendment, accounting, confidential communications, or inspection and copying, may contact Cigna Behavioral Health's Privacy Office at 888.433.5768 extension 2350. You may be directed to make your request directly to your health plan, as your plan may not have delegated administration of this process to Cigna Behavioral Health.

Internal Protection of Oral, Written and Electronic Protected Health Information

Cigna Behavioral Health is bound by the Cigna Behavioral Health Information Protection Policy, which is a set of principles concerning the safeguarding of Cigna Behavioral Health information as it applies to all methods used to collect, store and access that information. Cigna Behavioral Health employees must adhere to this policy in regards to Cigna Behavioral Health specific information or individually identifiable protected health information of our participants, in any medium. Cigna Behavioral Health employees must safeguard this information from any intentional and unintentional use. This policy includes procedures for corrective actions and employee sanctions if a Cigna Behavioral Health employee inappropriately uses ordiscloses protected health information.

Routine Uses and Disclosures of Protected Health Information

Cigna Behavioral Health will not use participants' confidential information or disclose it to others without the participant's authorization, except for the following purposes:

- Treatment: We may disclose participant's confidential information to the participant's health care practitioner for their provision, coordination or management of the participant's health care and related services.
- Payment: We may use and disclose participant's confidential information to obtain payment for the participant's coverage, and to determine and fulfill our responsibility to administer the participant's health plan benefits. We may also disclose the participant's confidential information to a health plan, third-party administrator or health care provider for its payment activities.
- Health Care Operations: We may use and disclose participant's confidential information for our health care operations. We may also disclose the participant's confidential information to a health plan or practitioner who has a relationship with the participant, so that it can conduct quality assessment and improvement activities.

Upon termination of our business associate relationship with a participant's health plan, we have procedures in place to protect and restrict further use of and access to protected health information we have received or created for purposes of our benefit administration.

- Disclosures to participants' Employer, as Sponsor of participants' Health Plan As a business associate of employer-sponsored health plans, we may disclose participants' confidential information to a participant's employer or to a company acting on the employer's behalf, so that it can monitor, audit and otherwise administer the employee health benefit plan in which the participant participates, as permitted by the plan's documents, or as required by law. The employer or plan sponsor may not use this information for employment-related decisions, and must designate the employees who have access to the information for plan administration, monitoring or auditing purposes. Disclosures to Cigna Behavioral Health Vendors and Accreditation Organizations. We may disclose participants' confidential information to companies with whom we contract, serving as our business associates, if they need it to perform the services we have requested. Our business associates are contractually bound to the same conditions and restrictions regarding the use and disclosure of protected health information as Cigna Behavioral Health, and must notify us of any use inconsistent with those restrictions and conditions. Cigna Behavioral Health also discloses confidential information to accreditation organizations such as the National Committee for Quality

Assurance (NCQA) when the NCQA auditors collect Health Plan Employer Data and Information Sets (HEDIS®)*** data for quality measurement purposes.

- Promotional Gift: We may use or disclose participant's confidential information to provide participants with a promotional gift of nominal value.
- Public Health Activities: We may disclose participant's confidential information for the following public health activities and purposes:
    - To report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability;
    - To report child abuse or neglect to a government authority that is authorized by law to receive such reports;
    - To report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity;
    - To alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.
- Health Oversight Activities: We may disclose participant's confidential information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance.
- For Research: We may disclose participant's confidential information for research purposes, subject to strict legal restrictions.
- To Comply with the Law: We may use and disclose participant's confidential information to comply with the law.
- Judicial and Administrative Proceedings: We may disclose participant's confidential information in a judicial or administrative proceeding or in response to a legal order.
- Law Enforcement Official: We may disclose participant's confidential information to the police of other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- Health or Safety: We may disclose participant's confidential information to prevent or lessen a serious and imminent threat to the participant's health or safety or the health and safety of the general public.
- Government Functions: We may disclose participant's confidential information to various departments of the government such as the U.S. military or the U.S. Department of State.
- Workers Compensation: We may disclose participant's confidential information when necessary to comply with workers' compensation laws.

Protection of Information Disclosed to Plan Sponsors or Employer

Employers are not permitted to use confidential information we disclose for purposes of plan administration, for any purpose other than administration of the participant’s health benefit plan. The employer’s health benefit plan documents will say whether or not the employer receives confidential information and will identify the employees who are authorized to receive participants confidential information.

Use of Authorizations

We will not use or disclose participants' confidential information for any purpose other than those described in this communication, without the participant's written authorization. A participant may revoke an authorization the participant had previously given by sending a written request to our Privacy Office, but not with respect to any actions we already have taken.

Access to Protected Health Information

Access to our facilities is limited to authorize personnel. We restrict internal access to confidential information to CIGNA Behavioral Health employees who need to know that information to conduct our business. Cigna Behavioral Health trains its employees on policies and procedures designed to protect privacy. Cigna Behavioral Health employees must make reasonable efforts to limit use, disclosure or requests for protected health information to the minimum necessary to accomplish the intended purposes of the use, disclosure or request. Cigna Behavioral Health employees will only access protected health information that is required by their specific job function.

*Cigna Behavioral Health refers to Cigna Behavioral Health, Inc., and subsidiaries of Cigna Behavioral Health, Inc., including Cigna Behavioral Health of California, Inc.

** To obtain a copy of a health plan's HIPAA Privacy mandated Notice of Privacy Practices, please contact the participant services number on the participant's health plan ID card.

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

Health Care Professional Forms (Appendix D)

Behavioral Treatment Record Review ToolPDF163KB11/21/2018

Coordination of BenefitsPDF17KB08/01/2013

EAP Clinical Assessment FormPDF40KB08/01/2013

EAP Statement of UnderstandingPDF2.44MB08/01/2013

ED IOP Concurrent Review FormPDF27KB08/01/2013

Electronic Payment and Remittance Reports Online Resource--05/22/2014

HCFA/CMS 1500Online Resource--04/03/2015

Informed Consent FormPDF14KB08/01/2013

Member Release of Information FormPDF96KB08/01/2013

MH IOP Concurrent Review FormPDF26KB08/01/2013

Provider Self-Introduction FormPDF173 KB05/09/2019

SA IOP Concurrent Review FormPDF28KB08/01/2013

Self-Pay AgreementPDF15KB08/01/2013

Specialty Attested FormPDF317kB04/11/2019

Specialty Attestation for ParticipationPDF96KB08/01/2013

Specialty Verified FormPDF172kB03/07/2019

Termination Form (Individually Contracted Providers)PDF181 KB10/09/2018

W-9 FormPDF54KB08/01/2013

Employee Assistance Program (EAP) Forms (Appendix E)

Document Title	Document Type
EAP Clinical Assessment Form	PDF
EAP Statement of Understanding	PDF

Specialty Networks and Forms (Appendix F)

Specialty Networks

Cigna Behavioral Health has identified clinical specialties that require specific attestation of competency by practitioners or verification of licensure by Cigna Behavioral Health, in order to list the specialty as an area of clinical practice. Cigna Behavioral Health staff will utilize a variety of means to ensure that the specialties listed in a practitioner's record are accurate, to promote quality customer care. The verification process will be completed during initial credentialing, when the practitioner requests to add a specialty to their profile, and during the recredentialing process. There are currently three different groups of specialties: self-reported specialties, attested specialties and verified specialties. Definition of Self-Reported Specialties: Specialties that can be listed as an area of practice based upon a practitioner's selection. Self-reported specialties include general areas of behavioral health treatment for which practitioners have received training as a licensed behavioral health practitioner.

Self-reported specialties include: Depression, Anxiety, Couples Counseling, Anger Management, Grief/Loss, Gay/Lesbian Issues, Domestic Violence and Faith-based Counseling. Definition of Attested Specialties: Specialties that can be listed as an area of practice based on education and experience, but do not require additional documentation.

Attested Specialties include: Sexual Disorders/Offenders, Autism, EAP (CIR, CEAP, Assessment/Referral, Employment Education, Management Referrals, Supervisor Training,) Developmental Disorders, DBT, Dual Diagnosis, Eating Disorders, EMDR, Neuropsychological testing, and Pain Management.

Definition of Verified Specialties: Practitioner has documentation, such as specific licensure or certification, to substantiate ability to provide specialty services.

Verified Specialties Include: Addictionology, Alcohol/Substance Abuse, Behavioral Pediatricians, Buprenorphine, Medication Management, SAP, SAE.

If a practitioner does not meet the criteria for any of the attested and/or verified specialties, these specialties will not be added to the practitioner's profile. If at any point Cigna Behavioral Health has been made aware that a practitioner no longer meets criteria for an attested or verified specialty, the specialty will be removed from the practitioner's data profile. This will not affect the practitioner’s network status or payment for services.

However, participants needing these specialty services will only be referred by Cigna Behavioral Health to those practitioners who have that specialty listed within their profile.

If you wish to add a verified or attested specialty to your profile, please utilize the following Verified Specialties and/or Attested Specialties form(s). To add specialties that are not included on the following forms (i.e. Self-Reported Specialties) please contact Provider Services at 800.926.2273.

Crisis Stabilization and Intermediate Care

Cigna Behavioral Health is committed to providing excellent service and quality of care to Cigna Behavioral Health participants. Cigna Behavioral Health Clinical Operations and Provider Relations staff have worked together to better understand crisis stabilization services. As a result, Cigna Behavioral Health has defined crisis stabilization services to provide different access levels based on the participant's needs.

Crisis Stabilization Unit

The use of Crisis Stabilization Unit may apply in those cases where a Crisis Stabilization Unit exists outside of an accredited hospital, but where 24-hour supervised and monitored services are available. The facility setting for a crisis stabilization bed, is within a unit that provides around-the-clock nursing and/or mental health staff supervision and continuous observation and control of behaviors to insure the safety of the individual and/or others.

- This level of care is for short-term crisis stabilization for those experiencing a mental health emergency.
- The purpose is to prevent further decompensation that would result in an inpatient admission.
- The typical length of stay is 1-7 days

This service provides:

- Evaluation and intervention for individuals with acute symptoms of a behavioral health or substance use disorder when the clinical presentation does not immediately indicate the need for a higher level of care.
- 24-hour supervised and monitored services
- Psychiatric consultation
- Evaluation of family and social support systems that identify both opportunities and challenges, and a plan to address the latter
- Linkage and referrals to long-term services/community services
- An individualized treatment plan
- May provide medication management
- May provide individual and group and family counseling
- A complete medical evaluation and basic medical procedures as indicated.

Note: When medical services are not available on site, the program must be able to ensure that the individual will be linked to appropriate treatment and providers within a reasonable timeframe.

The goals of the intervention at this level of care:

- Reduction of acute symptoms due to a mental health disorder or substance use disorder
- Reduction of potential for harm to self or others
- Active interventions within 6 hours of admission by a mental health clinician
- Identification and mobilization of available resources including support networks
- Intervention focused on factors relevant to the crisis.

Appropriate Interventions include assessment of support networks, identification and assessment of available services, mobilization of those services, and an estimate of the individual's ability to access services and participate in the treatment plan.

Note: This level of care is not appropriate for an individual who, by clinical presentation or history, requires the intensive structure of Acute Inpatient Treatment for safely and stabilization.

Intermediate Care

Intermediate Care is a level of intervention that provides precautionary and preventive care to a participant who presents with a level of acuity that if not addressed within 48-hours, could escalate to a higher level of care. The goal of our Intermediate Care network is to successfully link complex cases with practitioners who have the clinical expertise to manage specific diagnoses/problems for ongoing treatment. It is expected the intervention be conducted by a licensed mental health professional, the key elements being to assess, stabilize and proactively identify the most appropriate level of care for the participant at that time. The intervention should include the following components:

- A comprehensive psychiatric and medical history
- A description of the nature of the participant's impairments and the nature of any safety or risk issues (S/I, H/I)
- Comprehensive evaluation of substance abuse or chemical dependency issues
- A psychosocial evaluation including a systems analysis of the participant's family and support network. Identify any barriers for successful treatment plan
- Documentation of any current treatment practitioners, description of the services provided and medications, if any (including names, dosages, and frequencies on meds prescribed)

Following is a list of key objectives for Intermediate Care services:

- Practitioners will be able to intensify treatment plans as needed for their participants in order to prevent unnecessary hospitalization as clinical indicated
- Practitioners will develop short-term, evidenced-based treatment plans incorporating a systems approach
- Practitioners will include in their treatment planning, effective collaboration between Cigna Behavioral Health, psychiatrists, PCP's and other community resources prior to requesting any higher level of care

Notes

If the acuity of the participant's condition does not allow for preauthorization of coverage, contact Cigna Behavioral Health as soon as possible. Please be prepared to provide the following information to the Cigna Behavioral Health clinical staff:

- Participant's name, age, and participant identification number.
- History, diagnosis, indications, and nature of the immediate crisis.
- Alternative treatment provided or considered.
- Treatment goals, estimated length of stay, and discharge plans.

Meet and Greet Appointments

A Meet-&-Greet appointment is a pre-discharge visit conducted by a participating non-MD practitioner for the purpose of coordinating and scheduling the ambulatory follow-up appointment, 2-7 days after discharge. The practitioner will enter the facility as a visitor; therefore, the practitioner does not need to be credentialed with the facility. Please note that the Meet-&-Greet service is usually performed during visiting hours, but scheduling may vary by facility.

A Meet-&-Greet appointment is a Cigna Behavioral Health-initiated service for which prior authorization must be obtained from a Cigna Behavioral Health care manager or care coordinator. Claims should be submitted with CPT code 99499 (unlisted evaluation/management services). The claim will be processed for benefit as long as there is a

comment in the inpatient authorization and the practitioner includes a written description of the service provided, i.e. "pre-discharge consultation" or "Meet-&-Greet". Without a written description by the practitioner, the claim payment will be denied due to lack of information. A co-pay for this service depends upon the participant's benefit plan.

Behavioral Telehealth

Therapy and medication management telehealth sessions are available to Cigna customers nationwide and related claims will be administered in accordance with the customer's benefit plan. Offering services via telehealth to Cigna customers gives you the potential to broaden the scope of your practice, earn additional income during "off" hours, reach patients in a larger geographical area, expand access to mental health care, and reduce your time on the road.

You must be appropriately licensed in the state in which the customer is being treated. Use of a secure video-based technology* is preferred as it can provide you with information and a patient experience that is similar to an in-person examination. You must also be aware of relevant in-person and telehealth practice guidelines. You are expected to follow federal, state and local regulatory and licensure requirements related to your scope of practice, any limitations on the use of specific technologies and prescribing practices, and need to abide by state board and specialty training requirements.

Contracted behavioral providers who meet the telehealth specialty requirements may deliver services via telehealth with no additional credentialing. To provide telehealth sessions to Cigna customers, please attest to meeting the designated specialty requirements on the Attested Specialty Form. Upon receipt and approval by Cigna of the completed form, "telehealth" will be added as a specialty to your Cigna profile.

*Telephonic sessions are not considered to be a substitute for face-to-face or video therapy visits and require that specific criteria be met for approval.

Forms

Specialty Attested Form
Specialty Attestation for Participation
Specialty Verified Form

Primary Care Physician (PCP) Communication Information

Document Title	Document Type
Consent for Release of Confidential Information to Primary Care Care Physician	PDF
Draft Letter for Practitioners' Communications with Primary Care Physicians	PDF